Clinical & Legal Practice Standards for Conducting Competency to Stand Trial Evaluations & Restoration Services

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Indications for Raising the Issue of Competency to Stand Trial

Where to Have/ Ask to Have Evaluation Conducted

- Inpatient / Psychiatric Hospital Evaluation (API)
- Evaluation in Jail
- Outpatient / Community-based Evaluation
- Telemedicine Evaluation / Telephonic

When to Request a Competency Evaluation be Performed

- Drope v. Missouri, 420 U.S. 162 (1975)
- Jackson v. Indiana, 406 U.S. 715 (1972)
- Misdemeanor Charges - within 15 days
- Felony Charges – within 21-30 days

Appointment of a Neutral Evaluator

- Conflicts of Interest
- Qualifications of Examiner
- AK Rule Civ. Pro. 26 Disclosures
- Licensure in Alaska

Scheduling & Conducting the Examination

- Timing
- Records to provide examiner
- Attorney presence at exam

Contents of Competency Evaluation

- Clarification of referral source
- Description of records requested, received and reviewed
- Description of informed consent procedures / statement
- Purpose of evaluation
- Official version of offense alleged

Contents of Competency Evaluation Cont.

- Assessment techniques & results
- Prior social, medical, psychological, trauma, criminal history, educational, military and employment history
- Information gained from witnesses, family members, DOC employees / mental health staff or other collateral sources
- Response to prior / current psychiatric treatment

Contents of Competency Evaluation Cont.

- Diagnostic impressions based on history, Assessment tools, Current examination results
- Assessment of potential malingering
- Analysis of diagnosis as related to competency of Defendant to stand trial using the current legal standard in the Jurisdiction

Contents of Competency Evaluation Cont.

- Potential for dangerous behavior
- If first evaluation, recommendation as to whether Defendant is likely to be restored within a reasonable period of time
- Recommendation as to where restoration should take place
- Who should receive the competency evaluation report?

CST Assessment Tools

- Harvard University Medical School Competency Assessment Instrument
- MacArthur Competence Assessment Tool
- Competence Assessment for Standing Trial for Defendants with Mental Retardation
- Fitness Interview Test – Revised

Psychological Tests Often Employed in CST Evaluations

- MMPI - 2nd Ed. Minnesota Multiphasic Personality Inventory
- MCMI – III Millon Clinical Multiaxial Inventory
- WAIS IV – Wechsler Adult Intelligence Scale
- SIRS – Structured Interview of Reported Symptoms
- Hare PCL-R – Hare Psychopathy Check List
- MMSE – Mini-Mental Status Exam
- SASSI-3 – Substance Abuse Subtle Screening Inventory

Neuropsychological Assessment Tools

- Stroop – Color-Word Test
- Halstead Category Test
- Conners Continuous Performance Test - II
- Wechsler Memory Scale – Revised
- Wisconsin Card-Sorting Test
- Rey Complex Figure & Reconstruction Test

Malingering Assessment Tools

- Structured Inventory of Malingered Symptoms – ("SIMS")
- Test of Malingered Memory – ("TOMM")
- MacArthur Forensic Assessment of Symptoms Test – ("M-FAST")
- Validity Indicator Profile – ("VIP")

Developing a Competency Treatment Plan

- Diagnosis
- Medications
  - Dosages
  - Anticipated length if treatment
  - Involuntary medication (Sell v. U.S. 539 U.S. 166 (2003))
- Other forms of treatment
  - Education
  - Supportive counseling
  - Cognitive behavioral therapy
- Stakeholders involved

Competency Determination Hearings

- Misdemeanor Cases
- Felony Cases
- Uncontested findings of incompetence
- Contested Hearings
- Fluidity of (in-)competency
- Appointment of a tie-breaking opinion

Competency Determination Hearings Cont.

- Defendant's presence at hearing
- Court's ability to make observations of:
  - Defendant's behavior, competence, ability to communicate / collaborate with counsel
- Where to refer Defendants for Competency Restoration
- Length of time to commit a Defendant for competency restoration
- Restoration Status Reports

Where to Perform Restoration Services

- Jail Mental Health Pod:
  - Does not require hospital-level care to become clinically stable, well-established and effective treatment plan exists
- Hospital
  - Imminent danger to self / others, unknown or severe / complex psychopathology, strong possibility of malingering, Defendant lacks capacity to consent to treatment, need for close medical monitoring

Where to Perform Restoration Services Cont.

- Community
  - Defendant is compliant with effective treatment, best-suited to developmental disorders and/or cognitive impairments and Defendant has a stable, supportive living arrangement

Competency Restoration Services

- Psychopharmacology
  - Primary treatment modality for psychotic and/or affective disorders
- Psychoeducational Training
  - Primary treatment modality for cognitive disorders or developmental disabilities
    - Competency education
    - Mock Court Procedures
    - Essential vocabulary (receptive/ expressive)
    - Behavior Training
    - In Vivo sessions with defense attorney

Post-Restoration Competency Evaluation

- Opinion re: mental and clinical status resulting from treatment regimen
- Opinion re: Dusky standards of CST
  - Post-restoration evaluators should review and refer to original CST evaluation
- Should include an analysis of how restoration treatment plan addressed and resolved bases upon which Defendant was found incompetent

Maintaining Competency and Preventing Decompensation

- Adhering to the prescribed competency treatment plan
  - Ensure same medications are prescribed / renewed by DOC
- Make recommendations for improving Defendant's compliance with competency treatment plan
  - Transfer to jail mental health pod
  - Assign a designated treatment compliance case manager
  - Judge can encourage Defendant to comply voluntarily or risk forcible medication

Additional Topics

- Characteristics of Effective Expert Witness
- Juror Selection Variables
- Attributional biases between actors and observers

U.S. Supreme Court Cases

The following Supreme Court cases have a bearing on how mental competency issues are handled in state courts.

Dusky v. United States, 362 U.S. 402 (1960)
Test of defendant's competency to stand trial is whether he or she has sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding and whether he or she has a rational as well as a factual understanding of proceeding against him or her; it is not enough that he or she is oriented to time and place and has some recollection of events.

Pate v. Robinson, 383 U.S. 375 (1966)
Test of defendant's competency to stand trial is whether he or she has sufficient present ability to consult with his or her lawyer with a reasonable degree of rational understanding and whether he or she has a rational as well as a factual understanding of proceeding against him or her; it is not enough that he or she is oriented to time and place and has some recollection of events.

Jackson v. Indiana, 406 U.S. 715 (1972)
Jackson was committed to pretrial commitment under a state statute that had a more lenient commitment standard, and a more stringent release standard, than those generally applicable to persons not charged with offenses. The Court found that the effect of the standards was to permanently institutionalize Jackson and held that he was deprived of the equal protection of the laws.

Drope v. Missouri, 420 U.S. 162 (1975)
The Missouri courts failed to accord proper weight to the evidence suggesting petitioner's incompetence. When considered together with the information available prior to trial and the testimony of petitioner's wife at trial, the information concerning petitioner's suicide attempt created a sufficient doubt of his competence to stand trial to require further inquiry. Whatever the relationship between mental illness and incompetence to stand trial, in this case the bearing of the former on the latter was sufficiently likely that, in light of the evidence of petitioner's behavior including his suicide attempt, and there being no opportunity without his presence to evaluate that bearing in fact, the correct course was to suspend the trial until such an evaluation could be made.

Ford v. Wainwright, 477 U.S. 399 (1986)
The Eighth Amendment prohibits states from inflicting the penalty of death upon a prisoner who is insane, and Florida's procedures for determining the sanity of a death row prisoner was not "adequate to afford a full and fair hearing" on the critical issue, and therefore the habeas petitioner was entitled to an evidentiary hearing in the district court, de novo, on the question of his competence to be executed.

Godinez v. Moran, 509 U.S. 389 (1993)
The standard of competency for pleading guilty or waiving right to counsel is the same as the competency standard for standing trial: whether the defendant has "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as factual understanding of the proceedings against him," *Dusky v. United States*, 362 U.S. 402 (1960) (*per curiam*).

Estelle v. Smith, 451 U.S. 454 (1981)
Where prior to in-custody court-ordered psychiatric examination to determine competency to stand trial defendant had not been warned that he had the right to remain silent and that any statement made could be used against him at capital sentencing proceeding, admission at penalty phase of capital felony trial of psychiatrist's damaging testimony on crucial issue of future dangerousness violated the Fifth Amendment privilege against compelled self-incrimination; because of lack of appraisal of rights and a knowing waiver thereof, the death sentence could not stand. The defendant's Sixth Amendment right to counsel was violated as defense counsel was not notified in advance that the psychiatric examination would encompass issue of future dangerousness.

Medina v. California, 505 U.S. 437 (1992)
The Due Process Clause permits a State to require that a defendant claiming incompetence to stand trial bear the burden of proving so by a preponderance of the evidence.

Riggins v. Nevada, 504 U.S. 127 (1992)
Due process allows a mentally ill inmate to be treated involuntarily with antipsychotic drugs where there is a determination that the inmate is dangerous to himself and others and that the treatment is in his medical interest, but forcing antipsychotic drug on a convicted prisoner is impermissible absent a finding of overriding justification, and at least as much protection as also provided to persons detained for trial. It was error to order that defendant be administered antipsychotic drugs during the course of trial over his objection without findings that there were no less intrusive alternatives, that the medication was medically appropriate, and that it was essential for the sake of defendant's safety or the safety of others.

Cooper v. Oklahoma, 517 U.S. 348 (1996)
Oklahoma law presuming defendant is competent to stand trial unless he proves incompetence by clear and convincing evidence violates due process because the rule allows the State to try a defendant who is more likely than not incompetent.

Sell v. United States, 539 U.S. 166 (2003)
The Fifth Amendment Due Process Clause permits the government to involuntarily administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render

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that defendant competent to stand trial, but only if the treatment is medically appropriate, substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, necessary significantly to further important governmental trial-related interests.

Indiana v. Edwards, 554 U.S. 164 (2008)
The United States Constitution permits States to insist that those who are competent enough to stand trial but still suffer from severe mental illness to the point they are not competent to conduct trial proceedings by themselves be represented by counsel.

Jackson v. Indiana, 406 US 715 - Supreme Court 1972
406 U.S. 715 (1972)

JACKSON
v.
INDIANA.

No. 70-5009.

Supreme Court of United States.

Argued November 18, 1971.
Decided June 7, 1972.

CERTIORARI TO THE SUPREME COURT OF **INDIANA**.

717 *717 *Frank E. Spencer* argued the cause for petitioner. With him on the brief were *Robert Hollowell, Jr.,* and *Robert Robinson.*

Sheldon A. Breskow argued the cause for respondent. On the brief were *Theodore L. Sendak,* Attorney General of **Indiana**, and *William F. Thompson,* Assistant Attorney General.

MR. JUSTICE BLACKMUN delivered the opinion of the Court.

We are here concerned with the constitutionality of certain aspects of **Indiana's** system for pretrial commitment of one accused of crime.

Petitioner, Theon **Jackson**, is a mentally defective deaf mute with a mental level of a pre-school child. He cannot read, write, or otherwise communicate except through limited sign language. In May 1968, at age 27, he was charged in the Criminal Court of Marion County, **Indiana**, with separate robberies of two women. The offenses were alleged to have occurred the preceding July. The first involved property (a purse and its contents) of the value of four dollars. The second concerned five dollars in money. The record sheds no light on these charges since, upon receipt of not-guilty pleas from **Jackson**, the trial court set in motion the **Indiana** procedures for determining his competency to stand trial. Ind. Ann. Stat. § 9-1706a (Supp. 1971),[1] now Ind. Code 35-5-3-2 (1971).

718 *718 As the statute requires, the court appointed two psychiatrists to examine **Jackson**. A competency hearing was subsequently held at which petitioner was represented by counsel. The court received the examining doctors' joint written report and oral testimony from them and from a deaf-school interpreter through whom they had attempted to communicate with petitioner. The report concluded that **Jackson's** almost nonexistent communication skill, together with his lack of hearing and his mental deficiency, left him unable to understand the nature of the charges against him
719 or to participate in his defense. One doctor testified that it was extremely *719 unlikely that petitioner could ever learn to read or write and questioned whether petitioner even had the ability to develop any proficiency in sign language. He believed that the interpreter had not been able to communicate with petitioner to any great extent and testified that petitioner's "prognosis appears rather dim." The other doctor testified that even if **Jackson** were not a deaf mute, he would be incompetent to stand trial, and doubted whether petitioner had sufficient intelligence ever to develop the necessary communication skills. The interpreter testified that **Indiana** had no facilities that could help someone as badly off as **Jackson** to learn minimal communication skills.

On this evidence, the trial court found that **Jackson** "lack[ed] comprehension sufficient to make his defense," § 9-1706a, and ordered him committed to the **Indiana** Department of Mental Health until such time as that Department should certify to the court that "the defendant is sane."

Petitioner's counsel then filed a motion for a new trial, contending that there was no evidence that **Jackson** was "insane," or that he would ever attain a status which the court might regard as "sane" in the sense of competency to

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stand trial. Counsel argued that **Jackson's** commitment under these circumstances amounted to a "life sentence" without his ever having been convicted of a crime, and that the commitment therefore deprived **Jackson** of his Fourteenth Amendment rights to due process and equal protection, and constituted cruel and unusual punishment under the Eighth Amendment made applicable to the States through the Fourteenth. The trial court denied the motion. On appeal the Supreme Court of **Indiana** affirmed, with one judge dissenting. 253 Ind. 487, 255 N. E. 2d 515 (1970). Rehearing was denied, with two judges dissenting. We granted certiorari, 401 U. S. 973 (1971).

720 *720 For the reasons set forth below, we conclude that, on the record before us, **Indiana** cannot constitutionally commit the petitioner for an indefinite period simply on account of his incompetency to stand trial on the charges filed against him. Accordingly, we reverse.

I

INDIANA COMMITMENT PROCEDURES

Section 9-1706a contains both the procedural and substantive requirements for pretrial commitment of incompetent criminal defendants in **Indiana**. If at any time before submission of the case to the court or jury the trial judge has "reasonable ground" to believe the defendant "to be insane,"[2] he must appoint two examining physicians and schedule a competency hearing. The hearing is to the court alone, without a jury. The examining physicians' testimony and "other evidence" may be adduced on the issue of incompetency. If the court finds the defendant "has not comprehension sufficient to understand the proceedings and make his defense," trial is delayed or continued and the defendant is remanded to the state department of mental health to be confined in an "appropriate psychiatric institution." The section further provides that "[w]henever the defendant shall become sane" the superintendent of the institution shall certify that fact to the court, and the court shall order him brought on to trial. The court may also make such an order *sua sponte*. There is no statutory provision for periodic review of the defendant's condition by either the
721 court or mental health authorities. Section 9-1706a by its terms does not accord the *721 defendant any right to counsel at the competency hearing or otherwise describe the nature of the hearing; but **Jackson** was represented by counsel who cross-examined the testifying doctors carefully and called witnesses on behalf of the petitioner-defendant.

Petitioner's central contention is that the State, in seeking in effect to commit him to a mental institution indefinitely, should have been required to invoke the standards and procedures of Ind. Ann. Stat. § 22-1907, now Ind. Code 16-15-1-3 (1971), governing commitment of "feeble-minded" persons. That section provides that upon application of a "reputable citizen of the county" and accompanying certificate of a reputable physician that a person is "feeble-minded and is *not insane* or epileptic" (emphasis supplied), a circuit court judge shall appoint two physicians to examine such person. After notice, a hearing is held at which the patient is entitled to be represented by counsel. If the judge determines that the individual is indeed "feeble-minded," he enters an order of commitment and directs the clerk of the court to apply for the person's admission "to the superintendent of the institution for feeble-minded persons located in the district in which said county is situated." A person committed under this section may be released "at any time," provided that "in the judgment of the superintendent, the mental and physical condition of the patient justifies it." § 22-1814, now Ind. Code 16-15-4-12 (1971). The statutes do not define either "feeble-mindedness" or "insanity" as used in § 22-1907. But a statute establishing a special institution for care of such persons, § 22-1801, refers to the duty of the State to provide care for its citizens who are "feeble-minded, and are therefore unable properly to care for
722 themselves."[3] *722 These provisions evidently afford the State a vehicle for commitment of persons in need of custodial care who are "not insane" and therefore do not qualify as "mentally ill" under the State's general involuntary civil commitment scheme. See §§ 22-1201 to 22-1256, now Ind. Code 16-14-9-1 to 16-14-9-31, 16-13-2-9 to 16-13-2-10, 35-5-3-4, 16-14-14-1 to 16-14-14-19, and 16-14-15-5, 16-14-15-1, and 16-14-19-1 (1971).

Scant attention was paid this general civil commitment law by the **Indiana** courts in the present case. An understanding of it, however, is essential to a full airing of the equal protection claims raised by petitioner. Section 22-1201 (1) defines a "mentally ill person" as one who

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"is afflicted with a psychiatric disorder which substantially impairs his mental health; and, because of such psychiatric disorder, requires care, treatment, training or detention in the interest of the welfare of such person or the welfare of others of the community in which such person resides."

Section 22-1201 (2) defines a "psychiatric disorder" to be any mental illness or disease, including any mental deficiency, epilepsy, alcoholism, or drug addiction. Other sections specify procedures for involuntary commitment of "mentally ill" persons that are substantially similar to those for commitment of the feeble-minded. For example, a citizen's sworn statement and the statement of a physician are required. § 22-1212. The circuit court judge, the applicant, and the physician then consult to formulate a treatment plan. § 22-1213. Notice to the individual is required, § 22-1216, and he is examined by two physicians, § 22-1215. There are provisions for temporary commitment. A hearing is held before a judge on the issue of mental illness. §§ 22-1209, 22-1216, 22-1217. The individual has a right
723 of appeal. *723 § 22-1210. An individual adjudged mentally ill under these sections is remanded to the department of mental health for assignment to an appropriate institution. § 22-1209. Discharge is in the discretion of the superintendent of the particular institution to which the person is assigned, § 22-1223; Official Opinion No. 54, Opinions of the Attorney General of **Indiana**, Dec. 30, 1966. The individual, however, remains within the court's custody, and release can therefore be revoked upon a hearing. *Ibid.*

II

EQUAL PROTECTION

Because the evidence established little likelihood of improvement in petitioner's condition, he argues that commitment under § 9-1706a in his case amounted to a commitment for life. This deprived him of equal protection, he contends, because, absent the criminal charges pending against him, the State would have had to proceed under other statutes generally applicable to all other citizens: either the commitment procedures for feeble-minded persons, or those for mentally ill persons. He argues that under these other statutes (1) the decision whether to commit would have been made according to a different standard, (2) if commitment were warranted, applicable standards for release would have been more lenient, (3) if committed under § 22-1907, he could have been assigned to a special institution affording appropriate care, and (4) he would then have been entitled to certain privileges not now available to him.

In *Baxstrom* v. *Herold*, 383 U. S. 107 (1966), the Court held that a state prisoner civilly committed at the end of his prison sentence on the finding of a surrogate was denied equal protection when he was deprived of a jury trial that the
724 State made generally available *724 to all other persons civilly committed. Rejecting the State's argument that Baxstrom's conviction and sentence constituted adequate justification for the difference in procedures, the Court said that "there is no conceivable basis for distinguishing the commitment of a person who is nearing the end of a penal term from all other civil commitments." 383 U. S., at 111-112; see *United States ex rel. Schuster* v. *Herold*, 410 F. 2d 1071 (CA2), cert. denied, 396 U. S. 847 (1969). The Court also held that Baxstrom was denied equal protection by commitment to an institution maintained by the state corrections department for "dangerously mentally ill" persons, without a judicial determination of his "dangerous propensities" afforded all others so committed.

If criminal conviction and imposition of sentence are insufficient to justify less procedural and substantive protection against indefinite commitment than that generally available to all others, the mere filing of criminal charges surely cannot suffice. This was the precise holding of the Massachusetts Court in *Commonwealth* v. *Druken*, 356 Mass. 503, 507, 254 N. E. 2d 779, 781 (1969).[4] The *Baxstrom* principle also has been extended to commitment following an insanity acquittal, *Bolton* v. *Harris*, 130 U. S. App. D. C. 1, 395 F. 2d 642 (1968); *Cameron* v. *Mullen*, 128 U. S. App. D. C. 235, 387 F. 2d 193 (1967); *People* v. *Lally*, 19 N. Y. 2d 27, 224 N. E. 2d 87 (1966), and to commitment in lieu of
725 sentence following *725 conviction as a sex offender. *Humphrey* v. *Cady*, 405 U. S. 504 (1972).

Respondent argues, however, that because the record fails to establish affirmatively that **Jackson** will never improve, his commitment "until sane" is not really an indeterminate one. It is only temporary, pending possible change in his

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condition. Thus, presumably, it cannot be judged against commitments under other state statutes that are truly indeterminate. The State relies on the lack of "exactitude" with which psychiatry can predict the future course of mental illness, and on the Court's decision in what is claimed to be "a fact situation similar to the case at hand" in *Greenwood v. United States*, 350 U. S. 366 (1956).

Were the State's factual premise that **Jackson's** commitment is only temporary a valid one, this might well be a different case. But the record does not support that premise. One of the doctors testified that in his view **Jackson** would be unable to acquire the substantially improved communication skills that would be necessary for him to participate in any defense. The prognosis for petitioner's developing such skills, he testified, appeared "rather dim." In answer to a question whether **Jackson** would ever be able to comprehend the charges or participate in his defense, even after commitment and treatment, the doctor said, "I doubt it, I don't believe so." The other psychiatrist testified that even if **Jackson** were able to develop such skills, he would *still* be unable to comprehend the proceedings or aid counsel due to his mental deficiency. The interpreter, a supervising teacher at the state school for the deaf, said that he would not be able to serve as an interpreter for **Jackson** or aid him in participating in a trial, and that the State had no facilities that could, "after a length of time," aid **Jackson** in so participating. The court also heard petitioner's mother
726 testify that *726 **Jackson** already had undergone rudimentary out-patient training in communications skills from the deaf and dumb school in Indianapolis over a period of three years without noticeable success. There is nothing in the record that even points to any possibility that **Jackson's** present condition can be remedied at any future time.

Nor does *Greenwood*,[5] which concerned the constitutional validity of 18 U. S. C. §§ 4244 to 4248, lend support to respondent's position. That decision, addressing the "narrow constitutional issue raised by the order of commitment in the circumstances of this case," 350 U. S., at 375, upheld the Federal Government's constitutional authority to commit an individual found by the District Court to be "insane," incompetent to stand trial on outstanding criminal charges, and probably dangerous to the safety of the officers, property, or other interests of the United States. The *Greenwood* Court construed the federal statutes to deal "comprehensively" with defendants "who are insane or mentally incompetent to stand trial," and not merely with "the problem of temporary mental disorder." 350 U. S., at 373. Though Greenwood's prospects for improvement were slim, the Court held that "in the situation before us," where the District Court had made an explicit finding of dangerousness, that fact alone "does not defeat federal power to make this initial commitment." 350 U. S., at 375. No issue of equal protection was raised or decided. See Petitioner's Brief, No. 460, O. T. 1955, pp. 2, 7-9. It is clear that the Government's substantive power to commit on the particular findings made in that case was the sole question there decided. 350 U. S., at 376.

727 *727 We note also that neither the **Indiana** statute nor state practice makes the likelihood of the defendant's improvement a relevant factor. The State did not seek to make any such showing, and the record clearly establishes that the chances of **Jackson's** ever meeting the competency standards of § 9-1706a are at best minimal, if not nonexistent. The record also rebuts any contention that the commitment could contribute to **Jackson's** improvement. **Jackson's** § 9-1706a commitment is permanent in practical effect.

We therefore must turn to the question whether, because of the pendency of the criminal charges that triggered the State's invocation of § 9-1706a, **Jackson** was deprived of substantial rights to which he would have been entitled under either of the other two state commitment statutes. *Baxstrom* held that the State cannot withhold from a few the procedural protections or the substantive requirements for commitment that are available to all others. In this case commitment procedures under all three statutes appear substantially similar: notice, examination by two doctors, and a full judicial hearing at which the individual is represented by counsel and can cross-examine witnesses and introduce evidence. Under each of the three statutes, the commitment determination is made by the court alone, and appellate review is available.

In contrast, however, what the State must show to commit a defendant under § 9-1706a, and the circumstances under which an individual so committed may be released, are substantially different from the standards under the other two statutes.

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Under § 9-1706a, the State needed to show only **Jackson's** inability to stand trial. We are unable to say that, on the record before us, **Indiana** could have civilly committed him as mentally ill under § 22-1209 or committed him as feeble-
728 minded under § 22-1907. The *728 former requires at least (1) a showing of mental illness and (2) a showing that the individual is in need of "care, treatment, training or detention." § 22-1201 (1). Whether **Jackson's** mental deficiency would meet the first test is unclear; neither examining physician addressed himself to this. Furthermore, it is problematical whether commitment for "treatment" or "training" would be appropriate since the record establishes that none is available for **Jackson's** condition at any state institution. The record also fails to establish that **Jackson** is in need of custodial care or "detention." He has been employed at times, and there is no evidence that the care he long received at home has become inadequate. The statute appears to require an independent showing of dangerousness ("requires . . . detention in the interest of the welfare of such person or . . . others . . ."). Insofar as it may require such a showing, the pending criminal charges are insufficient to establish it, and no other supporting evidence was introduced. For the same reasons, we cannot say that this record would support a feeble-mindedness commitment under § 22-1907 on the ground that **Jackson** is "unable properly to care for [himself]."[6] § 22-1801.

More important, an individual committed as feeble-minded is eligible for release when his condition "justifies it," § 22-
729 1814, and an individual civilly committed as mentally ill when the "superintendent or administrator *729 shall discharge such person, *or* [when] cured of such illness." § 22-1223 (emphasis supplied). Thus, in either case release is appropriate when the individual no longer requires the custodial care or treatment or detention that occasioned the commitment, or when the department of mental health believes release would be in his best interests. The evidence available concerning **Jackson's** past employment and home care strongly suggests that under these standards he might be eligible for release at almost any time, even if he did not improve.[7] On the other hand, by the terms of his present § 9-1706a commitment, he will not be entitled to release at all, absent an unlikely substantial change for the better in his condition.[8]

Baxstrom did not deal with the standard for release, but its rationale is applicable here. The harm to the individual is just as great if the State, without reasonable justification, can apply standards making his commitment a permanent one when standards generally applicable to all others afford him a substantial opportunity for early release.

730 As we noted above, we cannot conclude that pending criminal charges provide a greater justification for different *730 treatment than conviction and sentence. Consequently, we hold that by subjecting **Jackson** to a more lenient commitment standard and to a more stringent standard of release than those generally applicable to all others not charged with offenses, and by thus condemning him in effect to permanent institutionalization without the showing required for commitment or the opportunity for release afforded by § 22-1209 or § 22-1907, **Indiana** deprived petitioner of equal protection of the laws under the Fourteenth Amendment.[9]

731 *731 III

DUE PROCESS

For reasons closely related to those discussed in Part II above, we also hold that **Indiana's** indefinite commitment of a criminal defendant solely on account of his incompetency to stand trial does not square with the Fourteenth Amendment's guarantee of due process.

A. *The Federal System.* In the federal criminal system, the constitutional issue posed here has not been encountered precisely because the federal statutes have been construed to require that a mentally incompetent defendant must also be found "dangerous" before he can be committed indefinitely. But the decisions have uniformly articulated the constitutional problems compelling this statutory interpretation.

The federal statute, 18 U. S. C. §§ 4244 to 4246, is not dissimilar to the **Indiana** law. It provides that a defendant found incompetent to stand trial may be committed "until the accused shall be mentally competent to stand trial or until the

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732 pending charges against him are disposed of according to law." § 4246. Section *732 4247, applicable on its face only to convicted criminals whose federal sentences are about to expire, permits commitment if the prisoner is (1) "insane or mentally incompetent" and (2) "will probably endanger the safety of the officers, the property, or other interests of the United States, and . . . suitable arrangements for the custody and care of the prisoner are not otherwise available," that is, in a state facility. See *Greenwood v. United States*, 350 U. S., at 373-374. One committed under this section, however, is entitled to release when any of the three conditions no longer obtains, "whichever event shall first occur." § 4248. Thus, a person committed under § 4247 must be released when he no longer is "dangerous."

In *Greenwood,* the Court upheld the pretrial commitment of a defendant who met all three conditions of § 4247, even though there was little likelihood that he would ever become competent to stand trial. Since Greenwood had not yet stood trial, his commitment was ostensibly under § 4244. By the related release provision, § 4246, he could not have been released until he became competent. But the District Court had in fact applied § 4247, and found specifically that Greenwood would be dangerous if not committed. This Court approved that approach, holding § 4247 applicable before trial as well as to those about to be released from sentence. 350 U. S., at 374. Accordingly, Greenwood was entitled to release when no longer dangerous, § 4248, even if he did not become competent to stand trial and thus did not meet the requirement of § 4246. Under these circumstances, the Court found the commitment constitutional.

Since *Greenwood,* federal courts without exception have found improper any straightforward application of §§ 4244
733 and 4246 to a defendant whose chance of attaining competency to stand trial is slim, thus effecting *733 an indefinite commitment on the ground of incompetency alone. *United States v. Curry*, 410 F. 2d 1372 (CA4 1969); *United States v. Walker*, 335 F. Supp. 705 (ND Cal. 1971); *Cook v. Ciccone*, 312 F. Supp. 822 (WD Mo. 1970); *United States v. Jackson*, 306 F. Supp. 4 (ND Cal. 1969); *Maurietta v. Ciccone*, 305 F. Supp. 775 (WD Mo. 1969). See *In re Harmon*, 425 F. 2d 916 (CA1 1970); *United States v. Klein*, 325 F. 2d 283 (CA2 1963); *Martin v. Settle*, 192 F. Supp. 156 (WD Mo. 1961); *Royal v. Settle*, 192 F. Supp. 176 (WD Mo. 1959). The holding in each of these cases was grounded in an expressed substantial doubt that §§ 4244 and 4246 could survive constitutional scrutiny if interpreted to authorize indefinite commitment.

These decisions have imposed a "rule of reasonableness" upon §§ 4244 and 4246. Without a finding of dangerousness, one committed thereunder can be held only for a "reasonable period of time" necessary to determine whether there is a substantial chance of his attaining the capacity to stand trial in the foreseeable future. If the chances are slight, or if the defendant does not in fact improve, then he must be released or granted a §§ 4247-4248 hearing.

B. *The States.* Some States[10] appear to commit indefinitely a defendant found incompetent to stand trial until he recovers competency. Other States require a finding of dangerousness to support such a commitment[11] or provide
734 forms of parole.[12] New York has recently *734 enacted legislation mandating release of incompetent defendants charged with misdemeanors after 90 days of commitment, and release and dismissal of charges against those accused of felonies after they have been committed for two-thirds of the maximum potential prison sentence.[13] The practice of automatic commitment with release conditioned solely upon attainment of competence has been decried on both policy and constitutional grounds.[14] Recommendations for changes made by commentators and study committees have included incorporation into pretrial commitment procedures of the equivalent of the federal "rule of reason," a requirement of a finding of dangerousness or of full-scale civil commitment, periodic review by court or mental health administrative personnel of the defendant's condition and progress, and provisions for ultimately dropping charges if the defendant does not improve.[15] One source of this criticism is undoubtedly the empirical data available which tend to show that many defendants committed before trial are never tried, and that those defendants committed pursuant to ordinary civil proceedings are, on the average, released sooner than defendants automatically
735 committed solely on account of their incapacity to stand trial.[16] Related to these statistics *735 are substantial doubts about whether the rationale for pretrial commitment—that care or treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions.[17] However, very few courts appear to have addressed the problem directly in the state context.

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In *United States ex rel. Wolfersdorf v. Johnston*, 317 F. Supp. 66 (SDNY 1970), an 86-year-old defendant committed for nearly 20 years as incompetent to stand trial on state murder and kidnaping charges applied for federal habeas corpus. He had been found "not dangerous," and suitable for civil commitment. The District Court granted relief. It held that petitioner's incarceration in an institution for the criminally insane constituted cruel and unusual punishment, and that the "shocking circumstances" of his commitment violated the Due Process Clause. The court quoted approvingly the language of *Cook* v. *Ciccone*, 312 F. Supp., at 824, concerning the "substantial injustice in keeping an unconvicted person in . . . custody to await trial where it is plainly evident his mental condition will not permit trial within a reasonable period of time."

In a 1970 case virtually indistinguishable from the one before us, the Illinois Supreme Court granted relief to an illiterate deaf mute who had been indicted for murder four years previously but found incompetent to stand trial on
736 account of his inability to communicate, and committed. *People ex rel. Myers* v. *Briggs*, 46 Ill. *736 2d 281, 263 N. E. 2d 109 (1970). The institution where petitioner was confined had determined, "[I]t now appears that [petitioner] will never acquire the necessary communication skills needed to participate and cooperate in his trial." Petitioner, however, was found to be functioning at a "nearly normal level of performance in areas other than communication." The State contended petitioner should not be released until his competency was restored. The Illinois Supreme Court disagreed. It held:

> "This court is of the opinion that this defendant, handicapped as he is and facing an indefinite commitment because of the pending indictment against him, should be given an opportunity to obtain a trial to determine whether or not he is guilty as charged or should be released." *Id.*, at 288, 263 N. E. 2d, at 113.

C. *This Case.* Respondent relies heavily on *Greenwood* to support **Jackson's** commitment. That decision is distinguishable. It upheld only the initial commitment without considering directly its duration or the standards for release. It justified the commitment by treating it as if accomplished under allied statutory provisions relating directly to the individual's "insanity" and society's interest in his indefinite commitment, factors not considered in **Jackson's** case. And it sustained commitment only upon the finding of dangerousness. As Part A, *supra,* shows, all these elements subsequently have been held not simply sufficient, but necessary, to sustain a commitment like the one involved here.

The States have traditionally exercised broad power to commit persons found to be mentally ill.[18] The substantive
737 limitations on the exercise of this power and the procedures for invoking it vary drastically among *737 the States.[19] The particular fashion in which the power is exercised—for instance, through various forms of civil commitment, defective delinquency laws, sexual psychopath laws, commitment of persons acquitted by reason of insanity—reflects different combinations of distinct bases for commitment sought to be vindicated.[20] The bases that have been articulated include dangerousness to self, dangerousness to others, and the need for care or treatment or training.[21] Considering the number of persons affected,[22] it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated.[23]

We need not address these broad questions here. It is clear that **Jackson's** commitment rests on proceedings that did
738 not purport to bring into play, indeed did not even consider relevant, *any* of the articulated bases for *738 exercise of **Indiana's** power of indefinite commitment. The state statutes contain at least two alternative methods for invoking this power. But **Jackson** was not afforded any "formal commitment proceedings addressed to [his] ability to function in society,"[24] or to society's interest in his restraint, or to the State's ability to aid him in attaining competency through custodial care or compulsory treatment, the ostensible purpose of the commitment. At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.

We hold, consequently, that a person charged by a State with a criminal offense who is committed solely on account of his incapacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined

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that this is not the case, then the State must either institute the customary civil commitment proceeding that would be required to commit indefinitely any other citizen, or release the defendant.[25] Furthermore, even if it is determined that the defendant probably soon will be able to stand trial, his continued commitment must be justified by progress toward that goal. In light of differing state facilities and procedures and a lack of evidence in this record, we do not think it appropriate for us to attempt to prescribe arbitrary time limits. We note, however, that petitioner **Jackson** has now
739 been confined for three and one-half years on a record that sufficiently establishes *739 the lack of a substantial probability that he will ever be able to participate fully in a trial.

These conclusions make it unnecessary for us to reach petitioner's Eighth-Fourteenth Amendment claim.

IV

DISPOSITION OF THE CHARGES

Petitioner also urges that fundamental fairness requires that the charges against him now be dismissed. The thrust of his argument is that the record amply establishes his lack of criminal responsibility at the time the crimes are alleged to have been committed. The **Indiana** court did not discuss this question. Apparently it believed that by reason of **Jackson's** incompetency commitment the State was entitled to hold the charges pending indefinitely. On this record, **Jackson's** claim is a substantial one. For a number of reasons, however, we believe the issue is not sufficiently ripe for ultimate decision by us at this time.

A. Petitioner argues that he has already made out a complete insanity defense. **Jackson's** criminal responsibility at the time of the alleged offenses, however, is a distinct issue from his competency to stand trial. The competency hearing below was not directed to criminal responsibility, and evidence relevant to it was presented only incidentally.[26] Thus, in any event, we would have to remand for further consideration of **Jackson's** condition in the light of **Indiana's** law of criminal responsibility.

740 *740 B. Dismissal of charges against an incompetent accused has usually been thought to be justified on grounds not squarely presented here: particularly, the Sixth-Fourteenth Amendment right to a speedy trial,[27] or the denial of due process inherent in holding pending criminal charges indefinitely over the head of one who will never have a chance to prove his innocence.[28] **Jackson** did not present the Sixth-Fourteenth Amendment issue to the state courts. Nor did the highest state court rule on the due process issue, if indeed it was presented to that court in precisely the above-described form. We think, in light of our holdings in Parts II and III, that the **Indiana** courts should have the first opportunity to determine these issues.

C. Both courts and commentators have noted the desirability of permitting some proceedings to go forward despite the defendant's incompetency.[29] For instance, § 4.06 (3) of the Model Penal Code would permit an incompetent accused's attorney to contest any issue "susceptible of fair determination prior to trial and without the personal participation of the defendant." An alternative draft of § 4.06 (4) of the Model Penal Code would also permit an
741 evidentiary hearing at which certain *741 defenses, not including lack of criminal responsibility, could be raised by defense counsel on the basis of which the court might quash the indictment. Some States have statutory provisions permitting pretrial motions to be made or even allowing the incompetent defendant a trial at which to establish his innocence, without permitting a conviction.[30] We do not read this Court's previous decisions[31] to preclude the States from allowing, at a minimum, an incompetent defendant to raise certain defenses such as insufficiency of the indictment, or make certain pretrial motions through counsel. Of course, if the **Indiana** courts conclude that **Jackson** was almost certainly not capable of criminal responsibility when the offenses were committed, dismissal of the charges might be warranted. But even if this is not the case, **Jackson** may have other good defenses that could sustain dismissal or acquittal and that might now be asserted. We do not know if **Indiana** would approve procedures such as those mentioned here, but these possibilities will be open on remand.

Reversed and remanded.

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MR. JUSTICE POWELL and MR. JUSTICE REHNQUIST took no part in the consideration or decision of this case.

[1] "9-1706a. Commitment before trial—Subsequent actions.—When at any time before the trial of any criminal cause or during the progress thereof and before the final submission of the cause to the court or jury trying the same, the court, either from his own knowledge or upon the suggestion of any person, has reasonable ground for believing the defendant to be insane, he shall immediately fix a time for a hearing to determine the question of the defendant's sanity and shall appoint two [2] competent disinterested physicians who shall examine the defendant upon the question of his sanity and testify concerning the same at the hearing. At the hearing, other evidence may be introduced to prove the defendant's sanity or insanity. If the court shall find that the defendant has comprehension sufficient to understand the nature of the criminal action against him and the proceedings thereon and to make his defense, the trial shall not be delayed or continued on the ground of the alleged insanity of the defendant. If the court shall find that the defendant has not comprehension sufficient to understand the proceedings and make his defense, the trial shall be delayed or continued on the ground of the alleged insanity of the defendant. If the court shall find that the defendant has not comprehension sufficient to understand the proceedings and make his defense, the court shall order the defendant committed to the department of mental health, to be confined by the department in an appropriate psychiatric institution. Whenever the defendant shall become sane the superintendent of the state psychiatric hospital shall certify the fact to the proper court, who shall enter an order on his record directing the sheriff to return the defendant, or the court may enter such order in the first instance whenever he shall be sufficiently advised of the defendant's restoration to sanity. Upon the return to court of any defendant so committed he or she shall then be placed upon trial for the criminal offense the same as if no delay or postponement had occurred by reason of defendant's insanity."

[2] The section refers at several points to the defendant's "sanity." This term is nowhere defined. In context, and in the absence of a contrary statutory construction by the state courts, it appears that the term is intended to be synonymous with competence to stand trial.

[3] Sections 22-1801 and 22-1907 would appear to be interdependent. See Official Opinion No. 49, Opinions of the Attorney General of **Indiana**, Sept. 26, 1958.

[4] See also Association of the Bar, City of New York, Special Committee on the Study of Commitment Procedures and the Law Relating to Incompetents, Second Report, Mental Illness, Due Process and the Criminal Defendant 1 (1968) (hereafter N. Y. Report):

"The basic and unifying thread which runs throughout our recommendations is a rejection of the notion that the mere fact of a criminal charge or conviction is a proper basis upon which to build other unnecessary, unprofitable, and essentially unfair distinctions among the mentally ill."

[5] This case is further discussed in connection with the due process claim. See Part III.

[6] Perhaps some confusion on this point is engendered by the fact that **Jackson's** counsel, far from asserting that the State could *not* commit him as feeble-minded under § 22-1907, actively sought such a commitment in the hope that **Jackson** would be assured assignment to a special institution. The **Indiana** Supreme Court thought this concern unnecessary. In any event, we do not suggest that a feeble-mindedness commitment would be inappropriate. We note only that there is nothing in *this* record to establish the need for custodial care that such a commitment seems to require under §§ 22-1907 and 22-1801.

[7] See President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (1969).

[8] Respondent argues that **Jackson** would not in fact be eligible for release under § 22-1907 or § 22-1223 if he did not improve since, if the authorities could not communicate with him, they could not decide whether his condition "justified" release. Respondent further argues that because no state court has ever construed the release provisions of any of the statutes, we are barred from relying upon any differences between them. This line of reasoning is unpersuasive. The plain language of the provisions, when applied to **Jackson's** particular history and condition, dictates different results. No state court has held that an **Indiana** defendant committed as incompetent is eligible for release when he no longer needs custodial care or treatment. The commitment order here clearly makes release dependent upon **Jackson's** regaining competency to stand trial.

[9] Petitioner also argues that the incompetency commitment deprived him of the right to be assigned to a special "institution for feeble-minded persons" to which he would have been statutorily directed by a § 22-1907 commitment. The State maintains two such institutions. The **Indiana** Supreme Court thought petitioner "failed to understand the statutory mechanisms" for assignment following commitment under the two procedures. 253 Ind., at 490, 255 N. E. 2d, at 517. It observed that since the mental health department now administers, in consolidated fashion, all the State's mental facilities including the two special institutions, see § 22-5001 to § 22-5036, now Ind. Code 16-13-1-1 to 16-13-1-31, 16-13-2-1, 16-13-2-7 to 16-13-2-8, 16-14-18-3 to 16-14-18-4 (1971), and since the

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special institutions are "appropriate psychiatric institutions" under § 9-1706a, considering **Jackson's** condition, his incompetency commitment can still culminate in assignment to a special facility. The State, in argument, went one step further. It contended that in practice the assignment process under all three statutes is identical: the individual is remanded to the central state authority, which assigns him to an appropriate institution regardless of how he was committed.

If true, such practice appears at first blush contrary to the mandate of § 22-1907, requiring the court clerk to seek assignment at one of the two special institutions. However, the relevant statutes, including that effecting consolidation of all mental health facilities under one department, have been enacted piecemeal, and older laws often not formally revised. Since the department of mental health has sole discretionary authority to transfer patients between any of the institutions it administers at any time, § 22-5032 (6) and § 22-301, there is evidently adequate statutory authority for consolidating the initial assignment decision.

Moreover, nothing in the record demonstrates that different or better treatment is available at a special institution than at the general facilities for the mentally ill. We are not faced here, as we were in *Baxstrom,* with commitment to a distinctly penal or maximum-security institution designed for dangerous inmates and not administered by the general state mental health authorities. Therefore, we cannot say that by virtue of his incompetency commitment **Jackson** has been denied an assignment or appropriate treatment to which those not charged with crimes would generally be entitled.

Similarly, **Jackson's** incompetency commitment did not deprive him of privileges such as furloughs to which he claims a feeble-mindedness commitment would entitle him. The statutes relate such privileges to particular institutions, not to the method of commitment. Thus patients assigned to the Muscatatuck institution are entitled to furloughs regardless of the statute under which they were committed; and persons committed as feeble-minded would not be entitled to furloughs if assigned to a general mental institution.

[10] Cal. Penal Code §§ 1370, 1371 (1970); Conn. Gen. Stat. Rev. § 54-40 (c) (1958); Minn. Stat. Ann. § 631.18 (Supp. 1972-1973); N. J. Rev. Stat. § 2A: 163-2 (1971); Ohio Rev. Code Ann. §§ 2945.37 and 2945.38 (1954); Wis. Stat. Ann. § 971.14 (1971). See Note, Incompetency to Stand Trial, 81 Harv. L. Rev. 454 (1967).

[11] Iowa Code Ann. § 783.3 (Supp. 1972); Okla. Stat. Ann., Tit. 22, § 1167 (1958); S. D. Comp. Laws Ann. § 23-38-6 (1967).

[12] Mich. Comp. Laws Ann. § 767.27a (8) (1967); Ore. Rev. Stat. § 426.300 (1) (1971); Wis. Stat. Ann. § 51.21 (6) (Supp. 1972).

[13] N. Y. Crim. Proc. Law § 730.50 (1971); see also Ill. Rev. Stat., c. 38, § 104-3 (c) (1971).

[14] Foote, A Comment on Pre-Trial Commitment of Criminal Defendants, 108 U. Pa. L. Rev. 832 (1960); Note, Incompetency to Stand Trial, 81 Harv. L. Rev. 454-456, 471-472 (1967); N. Y. Report 91-107.

[15] Judicial Conference of the District of Columbia Circuit, Report of the Committee on Problems Connected with Mental Examination of the Accused in Criminal Cases, Before Trial 49-52, 54-58, 133-146 (1965) (hereafter D. C. Report); N. Y. Report 73-124; Note, *supra,* 81 Harv. L. Rev., at 471-473.

[16] See Matthews, Mental Disability and the Criminal Law 138-140 (American Bar Foundation 1970); Morris, The Confusion of Confinement Syndrome: An Analysis of the Confinement of Mentally Ill Criminals and Ex-Criminals by the Department of Correction of the State of New York, 17 Buffalo L. Rev. 651 (1968); McGarry & Bendt, Criminal vs. Civil Commitment of Psychotic Offenders: A Seven-Year Follow-Up, 125 Am. J. Psychiatry 1387, 1391 (1969); D. C. Report 50-52.

[17] Note, *supra,* 81 Harv. L. Rev., at 472-473; American Bar Foundation, The Mentally Disabled and the Law 415-418 (rev. ed. 1971) (hereafter ABF Study); N. Y. Report 72-77, 102-105, 186-190.

[18] See generally ABF Study 34-59.

[19] *Id.*, at 36-49. The ABF Study shows that in nine States the sole criterion for involuntary commitment is dangerousness to self or others; in 18 other States the patient's need for care or treatment was an alternative basis; the latter was the sole basis in six additional States; a few States had no statutory criteria at all, presumably leaving the determination to judicial discretion.

[20] See Note, Civil Restraint, Mental Illness, and the Right to Treatment, 77 Yale L. J. 87 (1967).

[21] See Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 Harv. L. Rev. 1288, 1289-1297 (1966).

[22] In 1961, it was estimated that 90% of the approximately 800,000 patients in mental hospitals in this country had been involuntarily committed. Hearings on Constitutional Rights of the Mentally Ill before the Subcommittee on Constitutional Rights of the Senate Committee on the Judiciary, 87th Cong., 1st Sess., pt. 1, pp. 11, 43 (1961). Although later U. S. Census Bureau data for 1969 show a resident patient population almost 50% lower, other data from the U. S. Department of Health, Education, and Welfare

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estimate annual admissions to institutions to be almost equal to the patient population at any one time, about 380,000 persons per annum. See ABF Study xv.

[23] Cf. *Powell* v. *Texas*, 392 U. S. 514 (1968); *Robinson* v. *California*, 370 U. S. 660 (1962).

[24] *In re Harmon*, 425 F. 2d 916, 918 (CA1 1970).

[25] In this case, of course, **Jackson** or the State may seek his commitment under either the general civil commitment statutes or under those for the commitment of the feebleminded.

[26] One doctor testified that **Jackson** "probably knows in a general way the basic differences between right and wrong." The other doctor agreed, but also testified that **Jackson** probably had no grasp whatsoever of abstract concepts such as time, "like simple things of yesterday and tomorrow."

[27] *People ex rel. Myers* v. *Briggs*, 46 Ill. 2d 281, 287-288, 263 N. E. 2d 109, 112-113 (1970); *United States ex rel. Wolfersdorf* v. *Johnston*, 317 F. Supp. 66, 68 (SDNY 1970); *United States* v. ***Jackson***, 306 F. Supp. 4, 6 (ND Cal. 1969); see Foote, *supra*, n. 14, at 838-839; D. C. Report 145-146 (Recommendation No. 16).

[28] See cases cited in n. 27; N. Y. Report 119-121 (Recommendation No. 15); D. C. Report 52-53; Model Penal Code § 4.06 (2) (Proposed Official Draft 1962).

[29] *People ex rel. Myers* v. *Briggs*, *supra*, at 288, 263 N. E. 2d, at 113; *Neely* v. *Hogan*, 62 Misc. 2d 1056, 310 N. Y. S. 2d 63 (1970); N. Y. Report 115-123 (Recommendation No. 13); D. C. Report 143-144 (Recommendation No. 15); Foote, *supra*, n. 14, at 841-845; Model Penal Code § 4.06 (alternative subsections 3, 4) (Proposed Official Draft 1962); ABF Study 423.

[30] Wis. Stat. Ann. § 971.14 (6) (1971); N. Y. Crim. Proc. Law § 730.60 (5) (1971); Mass. Gen. Laws, c. 123, § 17 (Supp. 1972); Mont. Rev. Code Ann, § 95-506 (c) (1969); Md. Ann. Code, Art. 59, § 24 (a) (1972). See *Reg.* v. *Roberts*, [1953] 3 W. L. R. 178, [1953] 2 All. E. R. 340 (Devlin, J.).

[31] See *Pate* v. *Robinson*, 383 U. S. 375 (1966); *Bishop* v. *United States*, 350 U. S. 961 (1956).

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420 U.S. 162 (1975)

DROPE
v.
MISSOURI.

No. 73-6038.

Supreme Court of United States.

Argued November 13, 1974.
Decided February 19, 1975.

CERTIORARI TO THE COURT OF APPEALS OF MISSOURI FOR THE ST. LOUIS DISTRICT.

163 *163 *Thomas C. Walsh* argued the cause for petitioner. With him on the briefs was *Charles A. Weiss.*

Neil MacFarlane, Assistant Attorney General of Missouri, argued the cause for respondent. With him on the brief were *John C. Danforth,* Attorney General, and *David Robards,* Assistant Attorney General.

MR. CHIEF JUSTICE BURGER delivered the opinion of the Court.

We granted certiorari in this case to consider petitioner's claims that he was deprived of due process of law by the
164 failure of the trial court to order a psychiatric *164 examination with respect to his competence to stand trial and by the conduct in his absence of a portion of his trial on an indictment charging a capital offense.

I

In February 1969 an indictment was returned in the Circuit Court of St. Louis, Mo., charging petitioner and two others with the forcible rape of petitioner's wife. Following severance of petitioner's case from those of the other defendants and a continuance, on May 27 his counsel filed a motion for a continuance until September, in order that petitioner might be examined and receive psychiatric treatment. Treatment had been suggested by a psychiatrist who had examined petitioner at his counsel's request and whose report was attached to the motion.[1] On the same date
165 respondent, through the *165 Assistant Circuit Attorney, filed a document stating that the State did not oppose the motion for a psychiatric examination. Apparently no action was taken on the motion, and petitioner's case was continued until June 23, at which time his counsel objected to proceeding with the trial on the ground that he had understood the case would be continued until September and consequently was not prepared. He objected further "for the reason that the defendant is not a person of sound mind and should have a further psychiatric examination before the case should be forced to trial." App. 19. The trial judge noted that the motion for a continuance was not in proper form and that, although petitioner's counsel had agreed to file another, he had failed to do so, and he overruled his objections and directed that the case proceed to trial.

On June 24 a jury was empaneled, and the prosecution called petitioner's wife as its first witness. She testified that petitioner participated with four of his acquaintances in forcibly raping her and subjecting her to other bizarre abuse and indignities, but that she had resumed living *166 with him after the incident on the advice of petitioner's psychiatrist and so that their children would be taken care of. On cross-examination, she testified that she had told petitioner's attorney of her belief that her husband was sick and needed psychiatric care and that for these reasons she had signed a statement disavowing a desire to prosecute. She related that on several occasions when petitioner did not "get his way or [was] worried about something," he would roll down the stairs. She could explain such behavior only by relating "what they told him many times at City Hospital, that is something he does upon himself [*sic*]." *Id.,* at 47. However, she also stated that she was not convinced petitioner was sick after talking to his psychiatrist, and that she had changed her

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166 mind about not wanting to prosecute petitioner because, as she testified, he had "tried to choke me, tried to kill me" on
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the Sunday evening prior to trial. *Id.*, at 52.

The prosecution called three more witnesses, but did not conclude its case, before adjournment on June 24. The following morning, petitioner did not appear. When the trial judge directed counsel to proceed, petitioner's attorney moved for a mistrial "in view of the fact that the defendant, I am informed, shot himself this morning." App. 63. The trial judge denied the motion, stating that he had already decided the matter would proceed for trial, and when petitioner's counsel complained of the difficulty of proceeding without a client, the trial judge replied that the difficulty was brought about by petitioner, who was on bond and had a responsibility to be present. The prosecution then called four more witnesses and, after producing proof of a prior conviction,[2] rested its case. Petitioner's "Motion for Verdict of Acquittal,"
167 including *167 in effect a renewal of the motion for a mistrial, was denied, and his counsel stated that he had "no evidence to produce at this time under the circumstances." *Id.*, at 64. The jury returned a verdict of guilty, and on July 21, 1969, petitioner, who had been in the hospital for three weeks recovering from a bullet wound in the abdomen, appeared, and the trial court fixed the penalty at life imprisonment.

Petitioner filed a motion for a new trial, the burden of which was that the trial court had erred in proceeding with the trial when no evidence had been produced that his absence from the trial was voluntary. A hearing was held before the judge who had presided at trial. Petitioner testified that on June 25 he had gone to his brother's house and that he remembered nothing concerning the shooting except that he felt a burning pain in his stomach and later woke up in the hospital. He testified he did not remember talking to anyone at the hospital. The State presented evidence that upon admission to the hospital petitioner stated that he had shot himself because of " `some problem with the law,' " *id.*, at 90, and that he had told a policeman he had shot himself because "he was supposed to go to court for rape, and he didn't do it; he rather be [*sic*] dead than to go to trial for something he didn't do." *Id.*, at 97. The trial judge denied the motion. Stating that on the morning of petitioner's failure to appear he had received information on the telephone which was checked with the hospital, the judge concluded that petitioner had the burden of showing that his absence was not voluntary and found on the basis of the evidence that his absence " `was due to his own voluntary act in shooting himself; done for the very purpose of avoiding trial.' " *Id.*, at 103.

168 The Missouri Supreme Court affirmed, accepting the trial court's finding, in ruling on petitioner's motion for a *168 new trial, that his absence was voluntary,[3] and holding that there was "no logical basis" for positing a different rule with respect to waiver of the right to be present in capital cases[4] than that which applies in felony cases generally. 462 S. W. 2d 677, 683-684. The Missouri Supreme Court also held that the denial of petitioner's motion for a continuance of the trial in order to procure further psychiatric evaluation was not an abuse of discretion, noting that petitioner did not contend that he lacked the mental capacity to proceed with the trial.

In April 1971 petitioner filed a motion to vacate the judgment of conviction and sentence in the court where sentence had been imposed, pursuant to Missouri Supreme Court Rule 27.26.[5] He alleged that his rights under Mo. Rev. Stat. §
169 552.020 (2) (1969)[6] and his *169 constitutional rights had been violated by the failure to order a psychiatric examination prior to trial and by conducting the trial to conclusion in his absence. Petitioner also asserted that he had been denied the effective assistance of counsel, a claim which is not before us.

In July 1971 a hearing was held on the motion; petitioner called two psychiatrists as witnesses. The psychiatrist who had examined petitioner prior to his trial testified that in his opinion there was reasonable cause to believe that a person who attempted to commit suicide in the midst of a trial might not be mentally competent to understand the proceedings against him. Another psychiatrist, whose duties included the examination of accused persons under Mo. Rev. Stat. c. 552, testified that in his opinion a man who was charged with raping his wife and attempted suicide during his trial was in need of a psychiatric evaluation to find out his mental condition, and that there should be an evaluation to determine whether the person was competent to assist in his own defense and whether he was "malingering or did it intentionally or if it was due to a true psychiatric disorder." App. 156. The same psychiatrist stated that he had examined petitioner at City Hospital in 1965 and had found that he had psychiatric problems and was in need of care. Petitioner took the stand, repeating his previous testimony with respect to the shooting.

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In June 1972 the sentencing judge denied petitioner's Rule 27.26 motion, and the Missouri Court of Appeals affirmed. The Court of Appeals concluded that the provisions for psychiatric examinations and hearings under Mo. Rev. Stat. §
170 552.020 (1969) comported with the requirements *170 of *Pate* v. *Robinson*, 383 U. S. 375 (1966), and that the test of incompetence to stand trial was that stated in *Dusky* v. *United States*, 362 U. S. 402 (1960).[7] It reasoned that it was necessary to examine the indicia of petitioner's incompetence "at three different times— before the trial, during the trial after the suicide attempt, and at the time of the motion for new trial." 498 S. W. 2d 838, 842.

As to the situation before trial, the court held that the psychiatric report attached to petitioner's motion for a continuance did not raise a reasonable doubt of his fitness to proceed. Turning to the second time period, "during the trial after the suicide attempt," the court held that *Pate* v. *Robinson, supra*, which involved a competence hearing rather than a competence examination followed by a hearing, did not require that the examination and hearing be held during the trial rather than immediately thereafter. With regard to the period after trial, and accepting petitioner's contention that his was a "bona fide attempt at suicide," the court was of the view that the legal significance of the attempt under *Robinson* should be evaluated without resort to the psychiatric testimony presented at the Rule 27.26 hearing, which was not before the trial judge. It held that petitioner's suicide attempt did not create a reasonable doubt of his competence as a matter of law, that petitioner had failed to demonstrate the inadequacy of the procedures employed for protecting his rights, and that the finding of the trial court was not clearly erroneous.[8]

171 *171 Finally, the Missouri Court of Appeals rejected petitioner's claim that he was deprived of due process of law by the conduct of a portion of his trial in his absence; it noted that the State Supreme Court had upheld a finding of voluntary absence on petitioner's direct appeal and concluded that the psychiatrists' testimony at the Rule 27.26 hearing did not meet the burden of proof placed on petitioner. "Again we cannot hold the trial court's finding to be clearly erroneous." 498 S. W. 2d, at 843. We granted certiorari, and we now reverse.

II

It has long been accepted that a person whose mental condition is such that he lacks the capacity to understand the nature and object of the proceedings against him, to consult with counsel, and to assist in preparing his defense may not be subjected to a trial. Thus, Blackstone wrote that one who became "mad" after the commission of an offense should not be arraigned for it "because he is not able to plead to it with that advice and caution that he ought." Similarly, if he became "mad" after pleading, he should not be tried, "for how can he make his defense?" 4 W. Blackstone, Commentaries *24. See *Youtsey* v. *United States*, 97 F. 937, 940-946 (CA6 1899). Some have viewed the common-law prohibition "as a by-product of the ban against trials in *absentia;* the mentally incompetent defendant, though physically present in the courtroom, is in reality afforded no opportunity to defend himself." Foote, A Comment on Pre-Trial Commitment of Criminal Defendants, 108 U. Pa. L. Rev. 832, 834 (1960). See *Thomas* v. *Cunningham*, 313 F. 2d 934,
172 938 (CA4 1963). For our purposes, it suffices *172 to note that the prohibition is fundamental to an adversary system of justice. See generally Note, Incompetency to Stand Trial, 81 Harv. L. Rev. 455, 457-459 (1967). Accordingly, as to federal cases, we have approved a test of incompetence which seeks to ascertain whether a criminal defendant " `has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding—and whether he has a rational as well as factual understanding of the proceedings against him.' " *Dusky* v. *United States*, 362 U. S., at 402.

In *Pate* v. *Robinson*, 383 U. S. 375 (1966), we held that the failure to observe procedures adequate to protect a defendant's right not to be tried or convicted while incompetent to stand trial deprives him of his due process right to a fair trial. Although in *Robinson* we noted that Illinois "jealously guard[ed] this right," *id.*, at 385, we held that the failure of the state courts to invoke the statutory procedures deprived Robinson of the inquiry into the issue of his competence to stand trial to which, on the facts of the case, we concluded he was constitutionally entitled. The Court did not hold that the procedure prescribed by Ill. Rev. Stat., c. 38, § 104-2 (1963), was constitutionally mandated, although central to its discussion was the conclusion that the statutory procedure, if followed, was constitutionally adequate. See, *e. g.*, *United States* v. *Knohl*, 379 F. 2d 427, 434-435 (CA2), cert. denied, 389 U. S. 973 (1967); *United States ex rel. Evans* v. *LaVallee*, 446 F. 2d 782, 785-786 (CA2 1971), cert. denied, 404 U. S. 1020 (1972). Nor did the Court prescribe a

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general standard with respect to the nature or quantum of evidence necessary to require resort to an adequate
173 procedure.[9] Rather, it noted that *173 under the Illinois statute a hearing was required where the evidence raised a " `*bona fide* doubt' " as to a defendant's competence, and the Court concluded "that the evidence introduced on Robinson's behalf entitled him to a hearing on this issue." 383 U. S., at 385. See *United States* v. *Marshall*, 458 F. 2d 446, 450 (CA2 1972).

As was true of Illinois in *Robinson,* Missouri's statutory scheme "jealously guards" a defendant's right to a fair trial. Missouri Rev. Stat. § 552.020 (1) (1969) provides: "No person who as a result of mental disease or defect lacks capacity to understand the proceedings against him or to assist in his own defense shall be tried, convicted or sentenced for the commission of an offense so long as the incapacity endures." Section 552.020 (2), see n. 6, provides that a judge or magistrate shall, "upon his own motion or upon motion filed by the state or by or on behalf of the accused," order a psychiatric examination whenever he "has reasonable cause to believe that the accused has a mental disease or defect excluding fitness to proceed." Section 552.020 (3) prescribes the contents of a report of the psychiatric examination, and § 552.030 (6) requires the court to hold a hearing if the opinion relative to fitness to proceed which is required to be included in the report is contested. In addition, the trial court may conduct a hearing on its won motion. Such a procedure is, on its face, constitutionally adequate to protect a defendant's right not to be tried while legally incompetent. Our task is to determine whether the proceedings in this case were consistent with petitioner's right to a fair trial.

174 *174 At the outset we are met by respondent's argument that the Court is bound by "limitations placed on proceedings under" Missouri Supreme Court Rule 27.26. Brief for Respondent 23. Specifically, respondent notes that under Rule 27.26 (f) petitioner had "the burden of establishing his grounds for relief by a preponderance of the evidence," and that the appellate-review function of the Missouri Court of Appeals was limited by Rule 27.26 (j) "to a determination of whether the findings, conclusions and judgment of the trial court [were] clearly erroneous." It urges that the Rule was "designed . . . to provide a valuable post-conviction remedy and not to provide another direct appeal . . . ," and expresses concern that "the state-federal relationship . . . remain in proper balance." Brief for Respondent 22.

We share respondent's concern for this necessary balance, and we do not question the State's power, in post-conviction proceedings, to reallocate the respective burdens of the individual and the State and to delimit the scope of state appellate review. Cf. *Hawk* v. *Olson*, 326 U. S. 271, 279 (1945); *Conner* v. *Wingo*, 429 F. 2d 630, 637-639 (CA6 1970). At the same time we note that while proceedings under the Rule "ordinarily cannot be used as a substitute for direct appeal involving mere trial errors or as a substitute for a second appeal," nevertheless "trial errors affecting constitutional rights may be raised even though the error could have been raised on appeal." Mo. Sup. Ct. Rule 27.26 (b) (3).

In the present case there is no dispute as to the evidence possibly relevant to petitioner's mental condition that was before the trial court prior to trial and thereafter. Rather, the dispute concerns the inferences that were to be drawn from the undisputed evidence and whether, in light of what was then known, the failure to make further inquiry into
175 petitioner's competence to *175 stand trial, denied him a fair trial. In such circumstances we believe it is "incumbent upon us to analyze the facts in order that the appropriate enforcement of the federal right may be assured." *Norris* v. *Alabama*, 294 U. S. 587, 590 (1935).[10] "When the corrective process is provided by the state but error, in relation to the federal question of constitutional violation, creeps into the record, we have the responsibility to review the state proceedings." *Hawk* v. *Olson, supra*, at 276.

III

The sentencing judge and the Missouri Court of Appeals concluded that the psychiatric evaluation of petitioner attached to his pretrial motion for a continuance did not contain sufficient indicia of incompetence to stand trial to require further inquiry. Both courts mentioned aspects of the report suggesting competence, such as the impressions that petitioner did not have "any delusions, illusions, hallucinations . . . ," was "well oriented in all spheres," and "was able, without trouble, to answer questions testing judgment," but neither court mentioned the contrary data. The report also showed that

176 petitioner, although cooperative in the examination, "had difficulty in participating well," "had a difficult *176 time
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relating," and that he "was markedly circumstantial and irrelevant in his speech." In addition, neither court felt that petitioner's episodic irrational acts described in the report or the psychiatrist's diagnoses of "[b]orderline mental deficiency" and "[c]hronic [a]nxiety reaction with depression" created a sufficient doubt of competence to require further inquiry.[11]

It does not appear that the examining psychiatrist was asked to address himself to medical facts bearing specifically on the issue of petitioner's competence to stand trial, as distinguished from his mental and emotional condition generally. Thus, it is not surprising that before this Court the dispute centers on the inferences that could or should properly have been drawn from the report. Even where the issue is in focus we have recognized "the uncertainty of diagnosis in this field and the tentativeness of professional judgment." *Greenwood* v. *United States*, 350 U. S. 366, 375 (1956). Here the inquiry is rendered more difficult by the fact that a defendant's mental condition may be relevant to more than one legal issue, each governed by distinct rules reflecting quite different policies. See *Jackson* v. *Indiana*, 406 U. S. 715, 739 (1972); *Pate* v. *Robinson*, 383 U. S., at 388-389 (Harlan, J., dissenting); Weihofen, The Definition of Mental Illness, 21 Ohio St. L. J. 1 (1960).

Like the report itself, the motion for a continuance did not clearly suggest that petitioner's competence to stand trial was the question sought to be resolved. While we have expressed doubt that the right to further inquiry upon the question
177 can be waived, see *Pate* v. *Robinson*, 383 U. S., at 384, it is nevertheless true that judges must *177 depend to some extent on counsel to bring issues into focus. Petitioner's somewhat inartfully drawn motion for a continuance probably fell short of appropriate assistance to the trial court in that regard. However, we are constrained to disagree with the sentencing judge that counsel's pretrial contention that "the defendant is not a person of sound mind and should have a further psychiatric examination before the case should be forced to trial," did not raise the issue of petitioner's competence to stand trial.[12] This statement also may have tended to blur the aspect of petitioner's mental condition which would bear on his criminal responsibility and that which would bear on his competence to stand trial. However, at that stage, and with the obvious advantages of hindsight, it seems to us that it would have been, at the very least, the
178 better practice to order an immediate examination under Mo. Rev. Code § 552.020 (2) (1969).[13] It *178 is unnecessary for us to decide whether such examination was constitutionally required on the basis of what was then known to the trial court since in our view the question was settled by later events.

IV

Turning to the situation at petitioner's trial, the state courts viewed the evidence as failing to show that during trial petitioner had acted in a manner that would cause the trial court to doubt his competence. The testimony of petitioner's wife, some of which repeated and confirmed information contained in the psychiatric evaluation attached to petitioner's motion for a continuance, was given little weight.[14] Finally, the sentencing judge, relying on his finding on petitioner's motion for a new trial and although stating "that it does not take a psychiatrist to know that such a man has a problem and indicates poor judgment," App. 203, concluded that the "fact that Mr. Drope shot himself to avoid trial suggests very
179 *179 strongly an awareness of what was going on." *Id.*, at 208. The Missouri Court of Appeals, accepting *arguendo* petitioner's contention that his was "a bona fide attempt at suicide," refused to conclude "that as a matter of law an attempt at suicide creates a reasonable doubt as to the movant's competency to stand trial." *Id.*, at 222.

Notwithstanding the difficulty of making evaluations of the kind required in these circumstances, we conclude that the record reveals a failure to give proper weight to the information suggesting incompetence which came to light during trial. this is particularly so when viewed in the context of the events surrounding petitioner's suicide attempt and against the background of the pretrial showing. Although a defendant's demeanor during trial may be such as to obviate "the need for extensive reliance on psychiatric prediction concerning his capabilities," Note, 81 Harv.L. Rev., at 469, we concluded in *Pate* v. *Robinson*, 383 U. S., at 385-386, that "this reasoning offers no justification for ignoring the uncontradicted testimony of. . .[a] history of pronounced irrational behavior." We do not mean to suggest that the indicia of such behavior in this case approximated those in *Robinson*, but we believe the Missouri courts failed to consider and give proper weight to the record evidence. Too little weight was given to the testimony of petitioner's wife that on the

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Sunday prior to trial he tried to choke her to death. For a man whose fate depended in large measure on the indulgence of his wife, who had hesitated about pressing the prosecution, this hardly could be regarded as rational conduct.[15]

180 Moreover, in considering the indicia of petitioner's *180 incompetence separately, the state courts gave insufficient attention to the aggregate of those indicia in applying the objective standard of Mo. Rev. Stat. § 552.020 (2). We need not address the Court of Appeals' conclusion that an attempt to commit suicide does not create a reasonable doubt of competence to stand trial as a matter of law. As was true of the psychiatric evaluation, petitioner's attempt to commit suicide "did not stand alone." *Moore* v. *United States*, 464 F. 2d 663, 666 (CA9 1972). We conclude that when considered together with the information available prior to trial and the testimony of petitioner's wife at trial, the information concerning petitioner's suicide attempt created a sufficient doubt of his competence to stand trial to require further inquiry on the question.

The import of our decision in *Pate* v. *Robinson* is that evidence of a defendant's irrational behavior, his demeanor at trial, and any prior medical opinion on competence to stand trial are all relevant in determining whether further inquiry is required, but that even one of these factors standing alone may, in some circumstances, be sufficient. There are, of course, no fixed or immutable signs which invariably indicate the need for further inquiry to determine fitness to proceed; the question is often a difficult one in which a wide range of manifestations and subtle nuances are implicated. That they are difficult to evaluate is suggested by the varying opinions trained psychiatrists can entertain on the same facts.

Here, the evidence of irrational behavior prior to trial was weaker than in *Robinson,* but there was no opinion evidence as to petitioner's competence to stand trial. See n. 9, *supra*. Moreover, Robinson was present throughout his trial;

181 petitioner was absent for a crucial portion of his *181 trial. Petitioner's absence bears on the analysis in two ways: first, it was due to an act which suggests a rather substantial degree of mental instability contemporaneous with the trial, see *Pate* v. *Robinson*, 383 U. S. at 389 (Harlan, J., dissenting);[16] second, as a result of petitioner's absence the trial judge and defense counsel were no longer able to observe him in the context of the trial and to gauge from his demeanor whether he was able to cooperate with his attorney and to understand the nature and object of the proceedings against him.

Even when a defendant is competent at the commencement of his trial, a trial court must always be alert to circumstances suggesting a change that would render the accused unable to meet the standards of competence to stand trial. Whatever the relationship between mental illness and incompetence to stand trial, in this case the bearing of the former on the latter was sufficiently likely that, in light of the evidence of petitioner's behavior including his suicide attempt, and there being no opportunity without his presence to evaluate that bearing in fact, the correct course was to

182 suspend the trial until such an evaluation could be made.[17] That this might have *182 aborted the trial is a hard reality, but we cannot fail to note that such a result might have been avoided by prompt psychiatric examination before trial, when it was sought by petitioner.

V

Our resolution of the first issue raised by petitioner makes it unnecessary to decide whether, as he contends, it was constitutionally impermissible to conduct the remainder of his trial on a capital offense in his enforced absence from a self-inflicted wound. See *Diaz* v. *United States*, 223 U. S. 442, 445 (1912). However, even assuming the right to be present was one that could be waived, what we have already said makes it clear that there was an insufficient inquiry to afford a basis for deciding the issue of waiver. Cf. *Westbrook* v. *Arizona*, 384 U. S. 150 (1966); *United States* v. *Silva*, 418 F. 2d 328 (CA2 1969).

The Missouri Court of Appeals concluded that, had further inquiry into petitioner's competence to stand trial been constitutionally mandated in this case, it would have been permissible to defer it until the trial had been completed. Such a procedure may have advantages, at least where the defendant is present at the trial and the appropriate inquiry is implemented with dispatch. See Note, 81 Harv. L. Rev., at 469; *Hansford* v. *United States*, 127 U. S. App. D. C. 359, 360, 384 F. 2d 311, 312 (1966) (rehearing en banc denied) (statement of Leventhal, J.); *Jackson* v. *Indiana*, 406 U. S.,

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at 741. However, because of petitioner's absence during a critical stage of his trial, neither the judge nor counsel was able to observe him, and the hearing on his motion for a new trial, held approximately three months after the trial, was
183 not informed by an inquiry into either his competence to stand *183 trial or his capacity effectively to waive his right to be present.

The question remains whether petitioner's due process rights would be adequately protected by remanding the case now for a psychiatric examination aimed at establishing whether petitioner was in fact competent to stand trial in 1969. Given the inherent difficulties of such a *nunc pro tunc* determination under the most favorable circumstances, see *Pate* v. *Robinson*, 383 U. S., at 386-387; *Dusky* v. *United States*, 362 U. S., at 403, we cannot conclude that such a procedure would be adequate here. Cf. *Conner* v. *Wingo*, 429 F. 2d, at 639-640. The State is free to retry petitioner, assuming, of course, that at the time of such trial he is competent to be tried.

The judgment is reversed, and the cause is remanded for proceedings not inconsistent with this opinion.

Reversed and remanded.

[1] The motion recites: "Comes now the Defendant, JAMES E. DROPE, and states to the court that he has had a psychiatric examination made by Dr. Joseph F. Shuman, M. D., a copy of which report is attached hereto.

"Defendant moves the court to continue his case until September, 1969 in order that he might receive an Examination, Evaluation and psychiatric treatment, as suggested by Dr. Shuman, at the Malcomb Bliss Hospital in the City of St. Louis, Missouri." App. 7.

The report, in the form of a letter to petitioner's attorney, states that the psychiatrist examined petitioner on February 20, 1969. In a section entitled "Past Medical History" it describes petitioner as "markedly agitated and upset," noting that he "appeared to be cooperative in this examination, but he had difficulty in participating well." The report continues: "The patient had a difficult time relating. He was markedly circumstantial and irrelevant in his speech. . . . There was no sign as to the presence of any delusions, illusions, hallucinations, obsessions, ideas of reference, compulsions or phobias at this time.

"In a simple IQ exam Mr. Drope was able to achieve a score in the low normal range . . . . Mr. Drope was well oriented in all spheres. With much difficulty he was able to explain a few abstractions . . . . He was able, without trouble, to answer questions testing judgment. He had much difficulty even doing the simple counting and calculation problems." The report then recounts the details of a conversation between the psychiatrist and petitioner's wife. The latter admitted that she had left petitioner on a number of occasions because of his sexual perversions and described the "strange behavior" of petitioner, including falling down flights of stairs, as an attempt to gain sympathy from her. In a section entitled "Impression," the report states that petitioner had "always led a marginal existence," that he had a "history of anti-social conduct," but that there were no "strong sings of psychosis at this time." It concludes that petitioner "certainly needs the aid of a psychiatrist," and that he "is a very neurotic individual who is also depressed and perhaps he is depressed for most of the time," and it offers as diagnoses: "(1) Sociopathic personality disorder, sexual perversion. (2) Borderline mental deficiency. (3) Chronic Anxiety reaction with depression." *Id.*, at 11-12.

[2] Petitioner was tried as a second offender under Mo. Rev. Stat. § 556.280 (1969), having been convicted in 1958 of second-degree burglary and "stealing."

[3] As to the situation at trial, the Missouri Supreme Court stated: "We disagree with defendant's contention that there is `no evidence upon the record' that he voluntarily absented himself. The court made such a determination before proceeding with the trial, although the basis for that determination is not fully disclosed. However, when defendant is free on bond, and he does not appear at the appointed time, it is presumed that the absence is voluntary until established otherwise." 462 S. W. 2d 677, 681 (1971).

[4] At the time of petitioner's trial, rape was punishable by death under Mo. Rev. Stat. § 559.260 (1969), and respondent had not waived the death penalty.

[5] A petition for a writ of habeas corpus previously filed in the United States District Court for the Eastern District of Missouri had been dismissed without prejudice on April 1, 1971, for failure to exhaust available state remedies. See 28 U. S. C. §§ 2254 (b), (c).

[6] Subdivision 2 of § 552.020 provides in pertinent part: "Whenever any judge or magistrate has reasonable cause to believe that the accused has a mental disease or defect excluding fitness to proceed he shall, upon his own motion or upon motion filed by the state or by or on behalf of the accused, by order of record, appoint one or more private physicians to make a psychiatric examination of the accused or shall direct the superintendent of a facility of the division of mental diseases to have the accused so examined by one or more physicians whom the superintendent shall designate." Subdivision 3 delineates the requirements for reports of psychiatric

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examinations, and subdivision 6 requires the court to hold a hearing if the opinion relative to fitness to proceed which is required to be included in the report is contested.

[7] "[T]he `test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding —and whether he has a rational as well as factual understanding of the proceedings against him.' " See also Mo. Rev. Stat. § 552.020 (1) (1969).

[8] Under Missouri Supreme Court Rule 27.26 (f) (1969), the "prisoner has the burden of establishing his grounds for relief by a preponderance of the evidence." Appellate review is limited under Rule 27.26 (j) "to a determination of whether the findings, conclusions and judgment of the trial court are clearly erroneous."

[9] In discussing the evidence adduced at Robinson's trial, the Court did, however, indicate that a history of irrational behavior is a relevant factor which, on the record before it, was sufficient to require further inquiry notwithstanding Robinson's demeanor at trial and the stipulated opinion of a psychiatrist that Robinson knew the nature of the charges against him and could cooperate with counsel when the psychiatrist examined him two or three months before. See *infra,* at 180-181.

[10] "But `issue of fact' is a coat of many colors. It does not cover a conclusion drawn from uncontroverted happenings, when that conclusion incorporates standards of conduct or criteria for judgment which in themselves are decisive of constitutional rights. Such standards and criteria, measured against the requirements drawn from constitutional provisions, and their proper applications, are issues for this Court's adjudication. . . . Especially in cases arising under the Due Process Clause is it important to distinguish between issues of fact that are here foreclosed and issues which, though cast in the form of determinations of fact, are the very issues to review which this Court sits." *Watts* v. *Indiana,* 338 U. S. 49, 51 (1949) (opinion of Frankfurter, J.). See also *Culombe* v. *Connecticut,* 367 U. S. 568, 605 (1961) (opinion of Frankfurter, J.).

[11] See n. 1, *supra.* The Court of Appeals determined that the other diagnosis offered, "[s]ociopathic personality disorder, sexual perversion," was excluded as a "mental disease or defect" under Missouri law. See Mo. Rev. Stat. § 552.010 (1969).

[12] In a colloquy with the trial judge, petitioner's counsel noted that the examination and evaluation "could be done during the summer months and be ready for trial *or else the examination would eliminate trial by September.*" App. 17. (Emphasis added.)

[13] The sentencing judge observed that "motions for psychiatric examinations have often been made merely for the purpose of delay," and "estimated that almost seventy-five percent of those sent for psychiatric examinations are returned mentally competent." App. 202. Although we do not, of course, suggest that courts must accept without question a lawyer's representations concerning the competence of his client, see *United States ex rel. Rizzi* v. *Follette,* 367 F. 2d 559, 561 (CA2 1966), an expressed doubt in that regard by one with "the closest contact with the defendant," *Pate* v. *Robinson,* 383 U. S. 375, 391 (1966) (Harlan, J., dissenting), is unquestionably a factor which should be considered. Moreover, resolution of the issue of competence to stand trial at an early date best serves both the interests of fairness, see *Peyton* v. *Rowe,* 391 U. S. 54, 62 (1968), and of sound judicial administration. See Panel on Recognizing and Determining Mental Competency to Stand Trial—Insanity as a Defense, in Institutes on Sentencing. 37 F. R. D. 111, 155, 161 (1964). Realization of those facts may have prompted the practice, noted by the sentencing court, "of the Circuit Attorney at the time to consent in all cases to a psychiatric examination whether with or without merit and without looking into the matter further." App. 206.

[14] See n. 1, *supra.* The sentencing court noted: "She did testify in answer to the question `And at that time didn't you tell me that you felt your husband was sick and needed psychiatric care?' The answer `Yes.' There was also some evidence of disputes and trouble accompanied by some physical force between husband and wife but not to the extent to indicate inability to understand the proceedings. There was no recitation of facts upon which a layman could base the opinion that the defendant was insane except the testimony perhaps that he rolled down the steps but this occurred only two or three times over a period of eight or nine or ten years." App. 201. The Court of Appeals dealt with her testimony only insofar as it repeated information in the psychiatric evaluation. It concluded that her feelings that petitioner had mental problems "bore on his sexual perversions—not his competency," and that the stairs episodes "demonstrate[d] pique more than anything." 498 S. W. 2d, at 842.

[15] It appears that under Mo. Rev. Stat. § 546.260 (1969) petitioner's wife could not be compelled to testify against him. See *State* v. *Dunbar,* 360 Mo. 788, 230 S. W. 2d 845 (1950). Similarly, neither court mentioned Mrs. Drope's testimony concerning petitioner's consultations at City Hospital. At the Rule 27.26 hearing, it will be recalled, a psychiatrist testified that he had examined petitioner at City Hospital in 1965 and had determined that he was in need of psychiatric care.

[16] We assume, as did the Missouri Court of Appeals, that petitioner's was a "bona fide" suicide attempt, rather than, as respondent contends, malingering. In that regard, the hearsay information in the possession of the trial judge when he denied the motion for a mistrial suggested an intent on the part of petitioner to kill himself, and a self-inflicted wound near vital organs does not suggest malingering. Of course we also recognize that "the empirical relationship between mental illness and suicide" or suicide attempts is

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uncertain and that a suicide attempt need not always signal "an inability to perceive reality accurately, to reason logically and to make plans and carry them out in an organized fashion." Greenberg, Involuntary Psychiatric Commitments to Prevent Suicide, 49 N. Y. U. L. Rev. 227, 234, 236 (1974). See also Pokorny, Myths about Suicide, in Suicidal Behaviors 64-65 (H. Resnik ed. 1968).

[17] In reaching this conclusion we have not relied on the testimony of the psychiatrists at the Rule 27.26 hearing, which we agree with the Missouri Court of Appeals, is not relevant to the question before us.

Predicting Restorability of Incompetent Criminal Defendants

Douglas Mossman, MD

U.S. courts frequently require forensic examiners to offer opinions concerning the likelihood that criminal defendants found incompetent to stand trial can have their competence "restored" through treatment. Yet no jurisdiction has established legal guidelines for testimony concerning restorability, and several authors have suggested that mental health professionals cannot accurately predict whether treatment to restore competence will succeed. This study asked whether reliable information that is consistently available at the time of examination might support empirically grounded opinions about the likelihood of restoration. Using records from all 351 inpatient pretrial defendants who underwent competence restoration at a state psychiatric hospital from 1995 through 1999, I evaluated whether several types of information that are reliable and that could consistently be made available to forensic examiners—including evaluees' demographic characteristics, diagnoses, symptom patterns, criminal charges, number of prior public sector hospitalizations, and cumulative prior length of stay (LOS)—would predict outcome of restoration efforts. I modeled the probability of successful restoration using logistic regression equations, and evaluated the equations' predictive accuracy using *k*-fold cross-validation and receiver operating characteristic (ROC) analysis. Lower probability of restoration was associated with having a misdemeanor charge, longer cumulative LOS, older age, and diagnoses of mental retardation, schizophrenia, and schizoaffective disorder. Although the overall rate of successful restoration for felony defendants was 75 percent, logistic equations allowed selection of subgroups with high predicted probabilities of restoration (>90%) and low probabilities of restoration (<35%). In cross-validation simulations, predictive equations had ROC areas of 0.727 for all defendants, and 0.735 for felony defendants. These findings provide scientific support for testimony that two types of incompetent evaluees have well-below-average probabilities of being restored: chronically psychotic defendants with histories of lengthy inpatient hospitalizations and defendants whose incompetence stems from irremediable cognitive disorders (such as mental retardation). Nonetheless, courts may still deem low probabilities of success to be "substantial" enough to warrant attempts at restoration.

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For centuries, Anglo-American legal tradition has barred prosecution of accused criminals who are not mentally fit to defend themselves,[1–3] and in the 1960s and 1970s, Supreme Court decisions made assuring the competence of defendants a requirement of U.S. constitutional law.[4–6] Under criteria articulated in the landmark decision in *Dusky v. U.S.*, criminal prosecution may not take place unless a defendant "has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and "has a rational as well as factual understanding of the proceedings against him" (Ref. 4, p 402).

All U.S. jurisdictions have procedures for holding hearings and making determinations about a criminal defendant's adjudicative competence, or (to use the more common term) competence to stand trial (CST). Recent estimates suggest that each year 50,000 to 60,000 U.S. defendants undergo examinations to determine CST.[7,8] In about one fifth of these cases, trial courts conclude that defendants are incompetent.[9,10] Once they are found incompetent to stand trial (IST), most defendants undergo court-ordered "restoration"—mental health treatment and/or education aimed at enabling defendants to proceed with adjudication.[11,12] On any given date, defendants hospitalized for competence restoration occupy roughly 4,000 psychiatric hospital beds in

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the United States, or about one ninth of the nation's state psychiatric hospital beds.[13–15]

Inpatient restoration cannot be the automatic result of a trial court's finding of incompetence, however. In *Jackson v. Indiana*,[16] the U.S. Supreme Court held that it violated a pretrial defendant's constitutional right to due process to subject him to indefinite hospitalization solely because he was incompetent to stand trial. Under *Jackson*, an incompetent criminal defendant may not "be held more than the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that competency in the foreseeable future" (Ref. 16, p 738).

Most U.S. jurisdictions require examiners who believe that a defendant is IST to offer an opinion concerning the likelihood of the defendant's regaining competence if provided with a course of treatment.[17,18] Yet no jurisdiction has established legal guidelines concerning testimony about potential restoration, and previous publications suggest that mental health professionals encounter problems in making predictions about restorability.

A few years after the Supreme Court issued *Jackson*, Roesch and Golding[19] asserted that mental health professionals could not accurately assess the likelihoods of defendants' becoming competent with treatment, in part because the high base rate of successful restoration made it difficult to detect defendants who would not respond to treatment. Indeed, studies of defendants from Los Angeles,[20] Michigan,[21] Ohio,[22,23] and Oklahoma,[24] have shown that most defendants hospitalized for competence restoration regain their competence, and the few studies that examine prediction accuracy have yielded results that tend to confirm Roesch and Golding's pessimistic assessment.

An Illinois study found that clinicians were wrong in predicting treatment outcomes of 85 percent of the defendants who ultimately were not restored,[25] and Florida researchers concluded that a discriminant function they developed had "little or no better than chance utility in predicting" restorability (Ref. 26, p 73). A retrospective Oklahoma study[17] found that having a previous criminal record and alcohol use at the time of the offense modestly increased the likelihood of competence restoration; impairment in psycholegal ability, having psychotic symptoms, and aggression toward others after arrest were correlated with failure to attain competence. Nonetheless, the study's authors concluded that their results were "consistent with prior research in suggesting that examiners should exercise caution in providing feedback to courts concerning [the likely success of] competency restoration" (Ref. 17, p 377). A recent Alabama study[18] found few differences between defendants who examiners predicted were restorable or nonrestorable. Those differences that did exist reflected mainly nonpsychiatric variables such as criminal record, current criminal charge, and understanding of the legal process.

Summarizing previous research findings in the mid-1990s, Nicholson and colleagues concluded "that the ability of clinicians to predict competency restoration is poor, at least when compared with the base rate of failed restoration" (Ref. 17, p 373). Yet this conclusion seems at odds with research that has demonstrated associations between patient characteristics and treatment outcomes. For example, "[a] plethora of studies" (summarized in Ref. 27, p 48) have linked patients' clinical, demographic, and biological characteristics to good antipsychotic drug response. In addition, research suggests that certain patient characteristics, including duration of illness and lifetime hospitalization, are associated with lack of improvement during antipsychotic therapy.[28] It therefore seems reasonable to suppose that certain types of clinical information would provide a scientific, empirically grounded basis for forensic examiners' opinions about potential restorability. In the present study, I attempted to find out whether the types of reliable information that could be made consistently available when competence examinations take place might provide an empirical basis for forensic opinions about the likelihood of restoration.

Methods

Setting

This study used archival data from 1995 through 1999 admissions to a public-sector psychiatric hospital in Ohio. During the study period, the hospital served patients from four metropolitan areas and several suburban and rural regions. At the hospital, inpatient pretrial defendants undergoing competence restoration received several types of clinical interventions as deemed appropriate by their hospital clinicians. Most competence restorees participated in group psychotherapies (along with patients hospitalized for other reasons) designed to help patients un-

derstand their medication, develop better interpersonal skills, and refrain from drug misuse. Most IST patients with psychoses received either conventional or atypical antipsychotic drugs; those patients thought to have affective syndromes usually received mood stabilizers or antidepressants. Competence restorees participated in group didactic sessions focused on improving their factual grasp of legal proceedings, legal pleas, potential trial outcomes and consequences, and the roles of courtroom personnel. IST patients often received additional individual instruction aimed at helping them to understand and make decisions concerning their own legal cases.

Treatment teams (including a psychiatrist, a psychologist, a social worker, and a nurse) assessed patients' progress toward competence at least monthly. Patients regarded as competent by their treatment teams usually were discharged from the hospital to jail, to await disposition of their criminal cases.

Statutory Schemes

IST patients came to the hospital under two statutory schemes. Before July 1997, criminal courts in Ohio could order hospitalization only for incompetent defendants found to have a "substantial probability" of becoming competent with treatment. In felony cases, restoration efforts could last no longer than one third of the defendant's minimum sentence if convicted, up to a maximum of 15 months. Defendants charged with misdemeanors could receive treatment for up to one third of their maximum potential sentence, which translated into treatment periods of 10 to 60 days. In the last half of the study period, Ohio law required criminal courts to order treatment for all incompetent defendants. Depending on the seriousness of their charges, maximum restoration periods were 4 to 12 months for felony defendants and 30 to 60 days for misdemeanor defendants. (After the study period, the Ohio Supreme Court ruled the latter statutory scheme unconstitutional because it required treatment even when efforts at restoration would be futile.[29])

Under both statutory schemes, defendants who did not achieve competence during the statutorily permitted period had their charges dismissed. They then became subject to possible civil commitment and could face reindictment if released from the hospital before the statute of limitations had expired.

Procedures

This study received approval from the Institutional Review Board of Wright State University and from the Ohio Department of Mental Health (ODMH). Using computer and file records, I identified 351 treatment episodes that began in the years 1995 through 1999 in which IST patients underwent competence restoration. This five-year period was chosen because it was fairly recent, because referrals to the hospital and treatment of IST patients had been relatively homogeneous over the time span, and because all IST patients admitted during this five-year span had completed efforts at competence restoration when data collection began in late 2001.

An unanticipated feature of the 1995 through 1999 study period stemmed from the jurisdiction's practices concerning forced medication for refusing patients. Under these practices (which changed after the June 2003 *Sell v. U.S.* decision[30]), defendants usually came to the hospital with court orders that authorized administration of psychotropic medication irrespective of the defendants' wishes. When this had not occurred, trial courts would promptly issue orders authorizing involuntary medication after receiving notice from the hospital that a patient was refusing treatment. Once patients began receiving medication, clinical staff members employed various means to make sure patients were receiving and not diverting prescribed medications (e.g., administering liquid forms of medication, checking patients' mouths after administration, or having patients remain where they could be observed so that they would not surreptitiously regurgitate the medication). Whatever one thinks about the wisdom or constitutionality of these practices, they meant that this study could evaluate predictors of restorability (including medication responsiveness) of all IST defendants referred to the hospital.

Figure 1 describes the selection of files for data analysis. Excluded from analysis were the records of two patients who did not complete attempts at restoration at the hospital (one patient was transferred to another hospital after a few days; one patient died a few days after admission). In another 21 cases, hospitalizations represented patients' second or third episodes of competence restoration during the study period. To avoid statistical problems that might arise from multiple observations of the same subjects, I limited analyses to these patients' first episode of competence restoration. The remaining 328 epi-

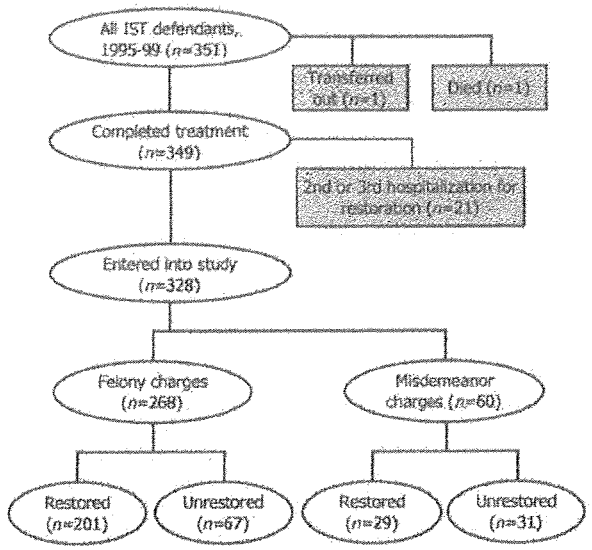

Figure 1. Selection of files for data analysis, showing the number of patients charged with felonies and misdemeanors and outcomes of restoration efforts.

sodes of care represented attempts at restoration for 268 felony defendants and 60 misdemeanor defendants. Table 1 provides detailed information about the patients' characteristics.

Computer databases provided patients' demographic information (sex, ethnicity, marital status, admission date, and birth date), multiaxial admission diagnoses, number of previous ODMH (i.e., public sector) hospitalizations, and cumulative length of stay (LOS) for all previous ODMH hospitalizations. The treating psychiatrists had rendered these diagnoses based on their patients' clinical presentations and all available psychiatric history, applying then-current *DSM-IV* criteria. Hospital charts (which contained photocopies of court filings) provided information about patients' criminal charges.

Before beginning treatment, each IST patient had undergone at least one court-ordered CST evaluation, usually performed by a local forensic assessment center independent of the hospital. Most referring courts provided the hospital with the written reports from these evaluations. For this study, I reviewed these reports and abstracted any information about specific symptoms that the competence examiners had adduced as directly responsible for each patient's incompetence. When copies of court-ordered reports were not on file, I reviewed the patient's admission psychiatric examinations for information about symptoms responsible for his adjudicative incompetence. Each incompetence-causing symptom was then classified as belonging within one of the four main components or symptom clusters—manic excitement/disorganization, depression/anxiety, negative symptoms, and positive symptoms—of the expanded Brief Psychiatric Rating Scale (BPRS–E), as described by Ruggeri and colleagues.[31] If more incompetence-causing symptoms fell within a single cluster than in any other single cluster, that cluster was recorded for the patient. (For example, suppose a report indicated four incompetence-causing symptoms for a patient. If two were positive symptoms, one was a negative symptom, and one was a depression/anxiety symptom, then "positive symptoms" was recorded for that patient.) Subsequently, this characterization of incompetence-causing symptoms was evaluated as a possible predictor of restorability.

Rationale for Variable Selection

Table 1 lists the study variables. Predictors to these variables were restricted for two reasons. First, the limited size of the database suggested that evaluating many more potential predictors might produce spuriously "significant" correlations. (Because predictors might be correlated but the degree of correlation was unknown, I could not use any simple Bonferroni-type level-of-significance correction to offset the statistical impact of multiple comparisons in the same variable set.) Second, I wished to evaluate only variables that had plausible potential relationships to restorability and that reflected information that evaluators could—and did—ascertain reliably at the time of evaluation or hospital admission.

Other patient characteristics (e.g., years of education, highest Global Assessment of Functioning Scale score for the past year, duration of illness, cumulative duration of treatment at non-ODMH facilities, and past responses to treatment) might have been useful indicators of restorability. Experience had shown, however, that evaluators often did not carefully explore these matters or could not obtain accurate information about them at the time of evaluation; thus, these factors could not function as reliably scored predictor variables. By contrast, demographic data, ODMH hospitalization history, currently observed symptoms, and initial diagnostic impressions were ascertained and recorded consistently. Including the number and cumulative duration of patients' previous public sector hospitalizations provided reliable (though imperfect) proxy indicators

Table 1 Characteristics of 328 Patients Undergoing Competence Restoration and Performance of Each Characteristic as a Predictor of Restoration

Characteristic	Restored	Not Restored	Test Statistics	p
Sex				
Female	28	18	$\chi^2 = 2.2$ ($df = 1$)	0.14
Male	202	80		
Age				
Mean ± SD	35.5 ± 11.8	39.0 ± 11.2	U = 13,379	0.0074
Range	18.1–79.2	18.2–84.5		
Ethnicity				
African-American	139	43		0.014*
European-American	88	53		
Other	3	2		
Marital status				
Never married	141	65		0.61*
Married	14	3		
Divorced/separated	49	23		
Widowed	3	1		
Unknown	23	6		
Intellectual functioning				
Mental retardation	15	17	$\chi^2 = 11.5$ ($df = 2$)	0.0073
Borderline	20	5		
Others	195	76		
Most serious charge				
Felony	201	67	$\chi^2 = 16.6$ ($df = 1$)	$<10^{-5}$
Misdemeanor	29	31		
Admission period				
Before mid-1997	123	62	$\chi^2 = 2.7$ ($df = 1$)	0.10
After mid-1997	107	36		
Clinical syndrome				
Schizophrenia/schizoaffective	103	63		0.0095*†
Major mood disorders	33	7		
Psychosis NOS	60	18		
Malingering	8	0		
Other diagnoses‡	26	10		
Symptom Clusters				
Manic excitement/disorganization	36	15		0.31*
Depression/anxiety	5	0		
Negative symptoms	6	0		
Positive symptoms	104	51		
No predominance	79	32		
Substance use disorder				
Present	124	41	$\chi^2 = 8.6$ ($df = 1$)	0.0033
Absent	106	57		
Prior hospitalizations				
Mean ± SD	3.23 ± 5.99	6.24 ± 7.62	U = 14,931.5	$<10^{-5}$
Range	0–37	0–39		
Previous LOS				
Mean ± SD	232 ± 642	1,018 ± 1,637	U = 15,699.5	$<10^{-5}$
Range	0–6301	0–8855		

*By two-sided Fisher exact test for $2 \times N$ tables.
†Post hoc test, schizophrenia/schizoaffective disorder versus other disorders: $\chi^2 = 10.5$ ($df = 1$), $p = 0.0012$.
‡This category included patients with various dementias and cognitive disorders, substance-induced disorders, delusional disorder, dysthymic disorder, paraphilias, adjustment disorders, impulse control disorders, and expressive language disorder. It also included patients without primary Axis I disorders (e.g., individuals with personality disorders or mental retardation).

of effectiveness of patients' previous treatment and the chronicity of their illnesses.

Admission dates were examined as a possible predictor to find out whether the mid-1997 statutory change affected the likelihood of success at restoration. I evaluated the presence or absence of retardation as a possible predictor variable, but not the severity of retardation, because all but three of the patients with diagnosed mental retardation were deemed to have "mild" retardation.

Outcome Criterion

My criterion for restoration was the treatment team's final assessment of each patient's competence. Three reasons supported using treatment teams' judgments rather than the ultimate determinations by referring trial courts. First, in most cases, criminal courts accepted hospital clinicians' opinions without hearing testimony or conducting any independent investigation of a defendant's competence. Second, I wanted to use a competence criterion that was uniform across patients, and I believed that opinions of clinicians at a single treating institution would be more uniform than opinions of dozens of criminal courts. Third, most instances in which trial courts' findings differed from the hospital's opinions involved former patients whom clinicians had treated and (in their opinion) restored to competence, who had returned to jail to await disposition, and who then experienced relapses or deterioration (frequently because the former patients stopped receiving medication after leaving the hospital). Given such instances, it seemed reasonable to assume that clinicians had made accurate assessments before hospital discharge and that courts' later findings of incompetence reflected post-hospitalization changes in defendants' mental conditions.

Statistical Procedures

Exploratory analyses individually examined each variable's capacity to predict success at restoration. Because misdemeanor defendants had statutorily truncated periods to regain competence, I evaluated variables using results for all 328 IST patients and for the 268 felony defendants alone. Backward stepwise logistic regression (implemented with SPSS 10.0 software using the likelihood ratio test) was used to generate prediction equations for all 328 IST patients and the 268-member subgroup who faced felony charges. When generating prediction equations, I coded as +1 or 0 the presence or absence of schizophrenia/schizoaffective disorder, mental retardation, felony charge, African-American ethnicity, diagnosis of substance use. The patients' ages, their numbers of prior ODMH hospitalizations, and their previous ODMH hospitalization days were entered as numeric values. The removal criterion was set at .01 to minimize "overfitting" of the prediction equations, but the reentry criterion was set at .05.

If one uses the same set of subjects both to produce a prediction procedure and to evaluate its accuracy, any resulting accuracy statistics will probably be overoptimistic (i.e., will overestimate the procedure's true accuracy in future subjects). Therefore, the accuracy of the prediction equations was assessed with k-fold cross-validation (with $k = 10$), a procedure that produces a nearly unbiased estimate of prediction accuracy.[32] The accuracy of the cross-validation "predictions" was quantified by using receiver operating characteristic (ROC) methods.

Results

Demographic and diagnostic variables of the patients appear in Table 1, accompanied by test statistics concerning each variable's association with competence restoration. For the full cohort of 328 IST patients, eight variables—misdemeanor charge, age at admission, mental retardation, having schizophrenia or schizoaffective disorder, number of previous ODMH hospitalizations, and cumulative previous LOS at ODMH hospitals, non-African-American ethnicity, and having a substance use disorder—were individually associated at the $p < .05$ level with reduced likelihood of restoration. Among the felony defendants, however, ethnicity and substance use diagnoses were not significantly associated with failure of restoration efforts. Stepwise logistic regression yielded the following three-variable predictive equation for the probability p of competence restoration among the full 328-member cohort of competence restorees:

$$\text{logit } p = .284 - 0.000807(LOS) - 1.213(MR) + 1.372(FEL) \quad (1)$$

In Equation 1, "logit p" equals the natural (Naperian) logarithm of $p/(1 - p)$, LOS denotes the patient's previous cumulative LOS, MR equals +1 if the patient had mental retardation and 0 otherwise, and FEL equals +1 if the patient faced a felony charge and 0 for a misdemeanor charge. The k-fold cross-validated value of the area under the curve (AUC) for Equation 1 was 0.727 ± 0.028 ($p < 10^{-5}$), equivalent to an effect size of $d = 0.853$.

Equation 1 implies that facing only a misdemeanor charge substantially reduced the odds of regaining competence. Given the relatively brief restoration periods permitted misdemeanor defendants, this finding was expected. Including misdemeanor defendants in the analysis may, on the one hand, have artificially improved classification accuracy by

including a marker for patients who had relatively short treatment episodes. On the other hand, including misdemeanor defendants may have statistically obscured other predictors of successful restoration when patients have longer treatment periods. I therefore evaluated potential predictors among the 268-member subgroup of felony defendants and obtained this equation:

$$\text{logit } p = 1.986 - 0.028\,(AGE) - 0.000763(LOS) - 0.709(SCHZ) - 1.509\,(MR) \quad (2)$$

In Equation 2, logit p, *LOS*, and *MR* have the same meanings and codings as in Equation 1; *AGE* is the patient's age when admitted; *SCHZ* was coded +1 if the patient's diagnosis was schizophrenia or schizoaffective disorder, and 0 otherwise. The AUC for this k-fold cross-validated predictive equation was 0.735 ± 0.032 ($p < 10^{-5}$), equivalent to an effect size of 0.889.

The AUC and effect size associated with Equation 2 imply that it does a respectable job of sorting restorable and nonrestorable defendants. But another way to evaluate the usefulness of a predictive equation is to consider whether it would let an evaluator identify a subgroup of IST defendants with probabilities of successful restoration that are well above or well below average. Setting p in Equation 2 at <.35 identified 18 IST felony defendants whose cross-validated probabilities of restoration were 35 percent or lower; of these 18 patients, only 5 (28%) achieved competence. For these patients, the median and average cumulative total LOSs were more than 10 years before they began efforts at competence restoration; their average age was 40.1 years; 14 (78%) of them had schizophrenia or schizoaffective disorder; and 8 (44%) had mental retardation.

By contrast, of the 60 patients facing felony charges who had the highest cross-validated probabilities of becoming competent, 56 (93%) were in fact restored. These 60 patients averaged just 24 days of total prior hospitalization; their average age was 26.6 years, only 7 (12%) of them had schizophrenia or schizoaffective disorder, and none had admission diagnoses of mental retardation. It is interesting to note that among the four nonrestored patients in this highest probability group, two had admission diagnoses of psychotic disorder not otherwise specified but discharge diagnoses of schizophrenia or schizoaffective disorder; the third patient had mental retardation diagnosed later in the hospitalization; and the fourth had a cognitive disorder attributed to congenital "brain damage." Thus, all four unrestored defendants from the 60 patients with the highest probabilities turned out to have conditions that this study suggests would reduce the likelihood of restoration.

Discussion

Most U.S. jurisdictions require examiners who conclude that a defendant is IST to offer an opinion concerning the likelihood of the defendant's regaining competence after treatment. In contrast to findings in several previous publications, this study suggests that specific clinical data could help competence examiners assess restorability.

Reasons for Success

The success of this study may have resulted from the use of variables that have plausibly strong relationships to being educable and likely to respond to treatment. I was especially fortunate to have data that identified patients who had spent many years of life hospitalized in public sector facilities, a clinical indicator implying poor response to past treatment efforts and probable poor response to future efforts. Individuals with mental retardation have (by definition) well-below-average intellectual ability, which *a fortiori* limits their capacity to grasp issues related to criminal proceedings. The correlation between age and restoration failure is consistent with studies indicating better antipsychotic response in younger individuals.[33–37] The comparative difficulty of restoring individuals with schizophrenia or schizoaffective disorder may reflect the neurocognitive deficits that underlie these conditions.[38–40]

I also may have had more success than previous investigators because of my jurisdiction's statutes and my method of selecting subjects. I examined records of all defendant-patients referred to my facility after they had completed statutorily defined restoration periods that were limited to 15 months. In contrast, previous investigators examined populations after just three months of hospitalization,[26] restricted their study population to discharged patients who came from a jurisdiction with an unspecified period for competence restoration,[24] or studied patients

where the statutorily permitted restoration period was much longer.[17] Assessing patients after just three months of treatment may lead one to misclassify some not-yet-competent-but-ultimately-restorable patients as simply unrestorable, and this may impede identification or optimal statistical weighting of variables that would predict ultimate outcome. Restricting the study group to discharged patients excludes the most impaired defendants, which may bias apparent outcomes and the value of possible predictor variables.[24] In jurisdictions with lengthy (unspecified or multiyear) restoration periods, some individuals who are treatment-resistant may become CST simply because of random variation in the severity of their illness rather than because they have received specific treatments. Including such patients might statistically obscure the value of variables that predict response to therapy.

Implications

Because this study's data came from a single state, a single facility, and a limited time period, I do not recommend that forensic examiners use my predictive equations to calculate probabilities of restoration. Rather, my findings provide support for two circumstances in which mental health experts may opine that treatment will have a low chance of restoring a felony defendant's adjudicative competence. First, if a defendant is incompetent because of a long-standing psychotic disorder that has resulted in lengthy periods of psychiatric hospitalization, this history supports an opinion that the defendant has a well-below-average probability of becoming competent with psychiatric treatment. Second, if a defendant has an irremediable cognitive disorder (e.g., mental retardation) and can grasp little information that the examiner attempts to convey during an evaluation, this finding would support a conclusion that restoration efforts will have well-below-average chances of success.

Though the previous paragraph's conclusions seem obvious, this is the first study to provide empirical support for them. Moreover, these findings provide a counterweight to previous conclusions that evaluators' ability to predict restoration is "poor" or "no better than chance." My findings suggest that, before rendering opinions about restorability of apparently incompetent defendants, forensic examiners may want to explore more carefully whether cognitively limited defendants have mental retardation and may want to review more carefully the collateral information about chronically psychotic defendants' treatment and hospitalization histories. Readers should note, however, that even when an evaluator identifies a defendant with a well-below-average probability of restoration, that defendant's likelihood of becoming competent with treatment may still be "substantial" enough for a court to order time-limited attempts at restoration. As the present study shows, even among defendants who had the lowest predicted probabilities of regaining competence, more than one-fourth became competent after treatment.

Limitations

My findings are limited by the retrospective, uncontrolled nature of this study. Also, I relied on archival data in hospital records, which contained conscientiously assembled but unsystematic observations and conclusions about patients. For this study's purposes, it would have been desirable to have forensic examiners systematically document defendants' symptoms using structured instruments, to have treating clinicians use structured interviews when arriving at diagnoses, and to have degrees of improvement in competence quantified by using standardized assessment instruments.

Yet these and other limitations in the study prompt five comments in defense of my efforts:

- First, although some forensic patients may welcome the chance to participate in research,[41] CST evaluees often will not or cannot participate in detailed, systematic assessments. I used data that always are or could be available for every evaluee.
- Second, when most of the subjects underwent evaluation and restoration, then-available instruments for assessing competence focused mainly on defendants' factual knowledge, and did not measure defendants' appreciation of or ability to reason about their situation.[9] Moreover, even the best currently available assessment tools are not meant to supplant clinicians' judgments, but to function only as guides for evaluators.[42,43]
- Third, prospective studies using systematic assessment measures have the drawback of not including individuals who will not or cannot give consent to participate. In the case of competence restorees, this could be a substantial fraction of

potential subjects.[44] After all, IST defendants are, by definition, impaired in their capacity to grasp information and/or collaborate. By contrast, this study, though limited to archival data, included every patient who underwent competence restoration at my facility during the study period.

- Fourth, IST patients are usually hospitalized under court order and frequently face serious charges. For these patients, the outcome of "successful" treatment is often prosecution and punishment.[15] Any prospective study that alters what otherwise would take place during a defendant's evaluation or treatment could affect the course of an ongoing criminal case. By using typical (if flawed) information available from already completed treatment episodes, this retrospective study obviated potential ethics concerns about changing the outcome of a defendant-patient's treatment or prosecution.
- Finally (and notwithstanding the previous point), I have identified factors that could be evaluated systematically and prospectively by other investigators working in different jurisdictions and with larger subject populations, without intruding inappropriately on legal proceedings or the ordinary process of assessment. For example, it would not be difficult for forensic evaluators to complete a BPRS for each evaluee using data ordinarily available from interviews, nor would it pose a problem for evaluators to complete a checklist indicating the principal signs or symptoms of illness that they believe are the causes of an incompetent evaluee's inability to stand trial. Although incompetence-causing symptom clusters were not predictive of restoration in this study, a more systematic assessment of symptoms during evaluation might yield a different finding. It also might be useful to study whether, at the time of evaluation, examiners could actually get better information about diagnoses, effectiveness of past treatment, or other indicators of illness chronicity and whether having such information would improve prospective assessments of restorability.

Conclusions

In contrast to previous reports, this study provides reason for some optimism about developing empirical guidelines for expert opinions about competence restoration. I hope the reported results will encourage other investigators to study a topic that affects many criminal defendants and a large fraction of patients in public-sector hospitals.

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THE UNRESTORABLE INCOMPETENT DEFENDANT: LENGTH OF ATTEMPTED RESTORATION AND FACTORS CONTRIBUTING TO A DECISION OF UNRESTORABLE

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The length of time for attempted restoration until an opinion is provided to the court that a defendant is unrestorably incompetent to stand trial is discussed. Factors potentially contributing to length of attempted restoration are also discussed along with a review of the relevant literature. Additionally, clinicians/administrators at forty-five public (state operated) forensic hospitals (representing forty-four states and the District of Columbia) were asked to provide information (primarily based on professional experience) about the amount of time required until an incompetent defendant is opined to be unrestorably incompetent to stand trial at their respective facilities. Also requested was information concerning diagnostic categories most often opined to be unrestorable. The length of time most frequently reported (mode) was twelve months (38% of the states), although responses varied considerably. Several states reported a bimodal distribution, that is, defendants with organic conditions were generally found unrestorable in considerably shorter periods of time than those experiencing non-organic psychosis. Developmental disability, severe dementia and brain injury, along with refractory and persistent mental illness, e.g., long-term schizophrenia, were cited as the clinical entities that most frequently led to an opinion of unrestorable to competency to stand trial. Additional factors reported to impact a decision of unrestorable were legislated requirements that a determination be made within a certain period of time, severity of the index offense(s) and medication trials.

In *Jackson v. Indiana* (1), the court ruled that those persons charged with a crime who are detained (generally in a state hospital) after their competence has been legally challenged, are entitled to due process and protection from unnecessarily prolonged detainment and denial of their liberties. The Court stated that a defendant "charged by a state with a criminal offense who is committed solely on the account of his capacity to proceed to trial cannot be held more than the reasonable period of time necessary to determine

whether there is a substantial probability that he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the state must either institute customary civil commitment proceedings that would be required to commit indefinitely any other citizen or release the defendant" (Headnote, 6). By contrast, in the case of *U.S. v. Ecker* (2) the Court decided that the defendant, who had a progressing dementia and was determined to be incompetent to stand trial, should be hospitalized for a reasonable amount of time to decide whether or not the defendant could be restored to competence even though prognosis for improvement was poor (3). Virginia law (the state in which the author practices) as in some other states, places a limit on the amount of time that a person can remain in a hospital for attempted restoration to competence, i.e., "Charges against an unrestorably incompetent defendant shall be dismissed on the date upon which his sentence would have expired had he been convicted and received the maximum sentence for the crime charged, or on the date five years from the date of the arrest for such charges, whichever is sooner [except in the case of capital murder]" (4).

States can vary considerably as to the amount of time allowed by law to attempt restoration, depending on the crime. Ohio's criteria are relatively short: one year for aggravated murder, murder and violent first and second degree felony charges, six months for all other felonies, sixty days for first and second degree misdemeanor charges and thirty days for all other misdemeanor charges (5). By contrast, Maryland requires that a determination be made after ten years for capital murder, five years for certain violent crimes and after three years or the maximum time the defendant would have been incarcerated if convicted for all other offenses (6). In Virginia, recent legislation allows for an indefinite period of restoration for cases of capital murder (7). Many states have no time limit and for those that do there can be considerable variation (8). The complex question arises of how long a period of attempted restoration is necessary to meet the criterion of "[can it be held

dants for purposes other than they were intended (e.g., to remove a "problem person" from the public) (8-10).

Data for restoration to competency to stand trial point to a decrease in length of stay over the past thirty-five years. McGarry in 1971 (11) found that defendants hospitalized for restoration to competency to stand trial at Bridgewater State Hospital (Massachusetts' maximum-security state facility) remained hospitalized for an average of fifteen years. Bennett and Kish (12), Golding et al. (13) and Rodenhouser and Khanis (14) all found average times to restoration to be approximately six months. Nicholson et al. (15) found that 90% of incompetent defendants were restored to competency after a mean of 280 days, or approximately nine months, while Mueller et al. (16) found that 76% of defendants were restored in approximately five months. However, when extreme deviations were removed, time to restoration was reduced to 110 days, or slightly less than four months. Hoge et al. (17) found that slightly over three months were required to restore persons to competency, and the Missouri Institute of Mental Health (18) reported that 78% of defendants were restored before three months, 20% from three to twelve months, and 2% after 12 months. Simon (19) reported an average of 135 days for restoration to competence to stand trial. While many studies can be found which address the amount of time it takes to restore to competency to stand trial, little information seems available specifically concerning the determination of unrestorability.

Mowbray (20) found 7.2% of incompetent defendants in their sample to be unrestorable and Lamb (21) reported 14.1%. Nicholson and McNulty (22) reported a much lower rate of unrestorable incompetent defendants (5.3%). A finding of unrestorability does not appear to be a frequent occurrence and seems to take place in about 10% (on the average) of those defendants in restoration status. Less information seems to be available on the length of time from when a defendant is admitted to a facility for restoration to when the determination of unrestorable is made. Likewise there appears to be little information concerning what factors contribute to a determination of unrestorable incompetence. Davis (23) reported that defendants who were not restored to competence to stand trial required significantly longer periods of hospitalization than those who were found competent. Nicholson and McNulty (22) reported lengths of stay to be much greater for persons who

were determined to be "persistently incompetent defendants" when compared to those who had been restored. They also concluded "given the limited evidence on the prediction of restoration per se, it follows that there is little evidence that mental health professionals are able to predict the length of time necessary for restoration" (p. 373).

Relationships have been demonstrated between certain psychological variables and whether or not a defendant has been restored to competence to stand trial. Anderson and Hewitt (24) found that higher I.Q. was predictive of restoration. Hoge et al. (17) found that the scores of restored defendants were less deviant on measures of psychopathology and higher on measures of intelligence than persons not restored. Degree of psychotic symptoms (especially conceptual disorganization, not hallucinations) has been found to be associated with an increased likelihood of incompetence (25-27). Rodenhauser and Khamis (14) found that a diagnosis of schizophrenia, previous hospitalizations, felony charges, drug treatment refusal, involuntary medication, physical restraint, and absence of personality disorders were all associated with increased length of hospitalization until restored. Ho (28) found that even with specialized programming designed to help mentally retarded defendants become competent, after five months the majority (76%) remained incompetent. There is some evidence that unrestorable mentally retarded defendants may be under-represented. Bonnie (29) found that mentally retarded defendants often do not overtly exhibit their lack of understanding of issues relevant to competence and therefore may be considered competent when in fact they are not. As one would expect, it appears that there is evidence that developmentally disabled persons or those with significant intellectual deficits as the result of some form of brain damage, as well as those persons exhibiting major mental illness, are more likely to be found nonrestorably incompetent than individuals of higher intellectual status and/or those seemingly less mentally ill. Other variables (some non-clinical, e.g., severity of crime) may also be operative and several authors (30-36) surmise that competence to stand trial is dependent on the legal context of a particular defendant's case and therefore take into consideration such factors as type of crime and complexities of the case.

SURVEY RESULTS

The author contacted, by telephone, state supported forensic facilities that were responsible for restoration of defendants found incompetent to stand trial. The author attempted to contact all states (including the District of Columbia) within the continental United States and was able to interview representatives from forty-five of the forty-eight states as well as the District of Columbia. Either a clinician who performs competency to stand trial evaluations on a regular basis (usually a clinical psychologist or psychiatrist) and/or an administrator, who had knowledge of time frames and numbers of evaluations, was interviewed for each state participating. The participants were asked to provide information (either data-based or if not available, clinical experience at that facility) about the length of time defendants would most frequently remain in restoration services until an opinion was rendered to the court that the defendant was unrestorably incompetent to stand trial. They were also asked to provide information about those factors which they believed might impact length of restoration, to include, but not be limited to, clinical variables, type of crime, legislative mandates and perceived administrative needs, e.g., pressure to free up hospital beds. Finally, they were asked to provide any other comments they wished about restoration and the unrestorable incompetent defendant. Thirty-seven of the forty-five facilities contacted provided a specific number representing the amount of time until determination. All but one provided an amount based on their knowledge/clinical experience as opposed to data-based information. Another six said they could not provide an amount, even an estimate. Two states indicated they had no unrestorable status. These results are presented in Table 1 below.

Given the variation of responses, average times were grouped as in Table 1. The most frequently reported length of time until defendants are determined unrestorable was 12 months (38% of the states surveyed that provided a specific response). Responses ranged from one month to twenty-four months with a mean of 11.24 months. Forty–three of the forty-five states responding provided an opinion concerning what clinical diagnosis was most likely to be found unrestorable (two states reported having no unrestorable status). Most states reported that unrestorable defendants exhibited either 1)

Table 1. Time Until Determination as Unrestorable

Length of Time Reported	Number of States
1-3 months	1
4-7 months	8
8-11 months	8
12 months	14
13-19 months	4
20-24 months	2
No opinion provided or no unrestorable status	8
Total states responding	45

Range = 1 to 24 months
Mean = 11.24 months

significant cognitive impairment (CI) and were developmentally disabled, brain injured, or experiencing a dementia or 2) refractory psychosis (RP): usually diagnosed with schizophrenia that was not responsive to different trials of medication (see Table 2). All but nine of the states providing an opinion, ranked the reason for not being able to restore as CI first and RP second. However, three of the forty-five states provided the opinion that CI defendants were the only diagnostic categories that had been determined to be unrestorable. Three states added a third ranked diagnosis of pervasive developmental disorder and still another three states added substance abuse/dependence as a third ranked diagnosis. All forty-two states that reported refractory psychosis as a contributor to determining unrestorable, reported that cognitive impairment was also a contributing factor. Several participants suggested that length of restoration until determining a defendant unrestorable was a bimodal distribution in which those persons with CI are found unrestorable within the first thirty days to three months while individuals with refractory psychosis reached a point of limited periods of restoration and opinion of unrestorable. Although not specifically asked as an aspect of this survey, many states mentioned non-diagnostic factors such as statutory time limits for restoration and nature of the defen-

offense (e.g., trespassing versus murder) as potential contributors to a determination of unrestorable.

Table 2. Ranking of Most Frequent Clinical Entities Contributing to Unrestorable

Clinical Entity	Number of States Reporting
Severe Cognitive Impairment (CI)	45
Refractory Psychosis (RP), e.g., chronic schizophrenia	42
Substance Abuse/Dependence	3
Severe or Pervasive Developmental Disorder (PDD)	3

- Three states reported CI only.
- All 42 states that reported RP also reported CI.
- The three states that reported substance abuse dependence and the three that reported pervasive developmental disorder ranked CI first and RP second.

DISCUSSION

Participants, based primarily on their professional experience, indicated that the most frequent length of time until defendants are reported to be unrestorable was just less than one year after admission to treatment for restoration. This represents a modal value and is subject to considerable variation from one month to two years. Clinical, legal and other contextual factors were reported to have a significant influence on the length of time. Several hospitals stated that if the defendant demonstrated clear indications of significant intellectual limitations (e.g., a developmental disability, dementia or brain damage) the finding of unrestorable might be made soon after admission, in a month to three months. Those surveyed estimated that the length of time was considerably longer for defendants experiencing chronic and treatment resistant major mental illness such as long-term retractable schizophrenia. These impressions seem reasonable when one considers that clinicians generally recognize that structural brain involvement can be irreversible and often does not respond favorably to treatment, while non-organically based psychotic defendants may respond to different trials of medication over time. Certainly caution is in order before making a determination of unrestorable

after too brief a period of attempted restoration. The courts may require that a reasonable effort was made to restore and that this effort was sufficient to rule out the likelihood of restoration in the foreseeable future.

Intellectual deficiency/brain injury does not necessarily preclude competence. Our experience as forensic evaluators has been that several defendants diagnosed as mentally retarded (in the mild to moderate range) have benefited from restoration efforts to the extent that they were able to meet criteria for competence. Other developmentally disabled persons, as well as some brain injured persons, may learn how not to expose their deficits by avoiding responding or passively acquiescing (29). These defendants will often indicate they have an understanding of trial concepts when in fact, on deeper investigation, it becomes clear they have little or no understanding. In addition, simply pointing to a full scale I.Q. as support for unrestorability can be misleading. A defendant may have poor spatial-organizational and motor skills which significantly impact overall I.Q., and still be quite capable in verbal areas which are important to understanding court related concepts. In the final analysis, it seems important to keep in mind that the assessment of competence is a functional assessment and while there certainly is an inverse correlation between low intellect/organic involvement and competence, this relationship is far from perfect. Therefore, the structure and content of the competency interviews for developmentally disabled persons deserve special scrutiny and may require additional time, as necessary, for an accurate assessment.

Persons with non-organic psychosis which impedes competence seem more amenable to treatment and potentially more able to respond to psychosocial interventions when compared to the brain injured person or the developmentally disabled. The effectiveness of medication in ameliorating symptoms of major mental illness is well known. The fact that a long-term mentally ill defendant has exhibited disorganized thinking and incoherence for many years, albeit on medications, is information that can be helpful in possibly expediting a determination of unrestorability if otherwise warranted. Some defendants have a known history of responding positively to medication; when this is the case, an attempted period of restoration may be expedited since the defendant is a known responder and therefore more likely to be restored than defendants known not to respond well to medication. Again,

several trials of medication and attempts at different forms of restoration education/therapy may be required to determine with some certainty that a psychotic defendant is likely unrestorable in the foreseeable future. One of the directors of forensic services surveyed reported that it is the policy of his facility to promote up to three trials of different medications before seriously considering a disposition of unrestorable. From the results of this survey, it would appear that after a year (if not sooner) of attempted intervention, clinicians may want to debate the efficacy of further treatment. The gravity of calling a defendant unrestorable, depending on the context of the case, requires diligent scrutiny. For both long-term psychotic and developmentally disabled defendants, the subject's treatment history can be a useful indicator for the final determination of whether or not a defendant will likely improve in the foreseeable future to the point that he/she can become competent to stand trial.

The context of the circumstances involved in a defendant's legal process appears relevant (30-36) and could have an impact on the decision to opine whether or not a defendant is unrestorable to competence. The type of crime was mentioned several times by participants as a factor in the determination of a defendant as unrestorable and statutory guidelines that differentiate types of crimes may play some role in the length of time until a defendant is reported to be unrestorable. As mentioned, some states, such as Ohio (5), require a determination to be made within a relatively short period from the time of admission depending on the index offense (e.g., thirty days for a less serious misdemeanor). Other states have a much longer period of time before an opinion must be given (4, 6). Statutory limits likely promote more frequent assessment of defendants, or at least earlier assessment, than if there was no legal requirement to do so, which could result in earlier determination as unrestorable. The complexities that could arise during a trial and legal proceedings because of the type of crime and the capacity/rationality required of the defendant to address those complexities also seem relevant. A defendant charged with shoplifting a candy bar would likely require less active participation and understanding during a trial than would be required of a defendant charged with capital murder. This is not necessarily due to the differences in the crimes themselves, but a result of the added complexities of a trial process for a crime with potentially grave outcome(s), e.g., expert

testimony, prolonged hearings), and mental illness as possible mitigation. Therefore, the meaning of having a rational understanding and the ability to assist counsel with the defense process can vary from crime to crime and, as the trial process is considered to be more complex, the criteria for unrestorably incompetent may change to reflect the complexities. An additional factor is that competency restoration involves the ability of the individual to perform some rational decision making in determining an appropriate plea. This too can be contextual, such as the importance of the defendant's capacity to weigh options in considering a potential insanity plea (34, 36). Caution is in order and even those defendants charged with less serious crimes may also need to understand relatively complex issues if the process so warrants.

Some participants mentioned the fact that evaluators may be required to assess risk of dangerousness/need for hospitalization when considering commitment versus community placement, after a determination as unrestorable. The degree of perceived risk could also have an impact on the amount of time until (or if ever) the defendant is declared unrestorable in some cases, e.g., sex offenders or murderers. Not only is it considered important that such persons are brought to justice, but they may also be viewed as threats if civilly committed as unrestorable and no longer under court jurisdiction/control. Once committed, a hospital may exercise certain options to include discharging the defendant to a community setting which may or may not be perceived as the most desirable outcome in the eyes of the public or others. Consequently, extending the period for attempting restoration in hope of achieving competence may seem warranted. Other non-legal or non-clinical contextual factors can also have an impact on length of time until a defendant is declared unrestorable. Some states mentioned a perceived pressure to discharge patients so that new patients can be admitted for restoration, reducing waiting lists. Others reported they have no such pressure. While evaluators should not make clinical decisions based on non clinical influences, the perceived needs of superiors and the host organization can introduce bias. A viable (or not so subtle) shift downward in competency criteria may expedite discharge, opening more hospital beds and reduce the number of defendants on waiting lists.

Interestingly, few participants mentioned dually diagnosed defendants, that is, those defendants with a developmental disability for some form of

organic impairment) who are also chronically mentally ill, e.g., schizophrenia. We have experienced several such cases and find these defendants to be a challenge, requiring considerable time to restore or make a final determination as unrestorable. If the psychosis improves such that it no longer interferes with trial competence, treating/evaluating clinicians may be left with the impact of low intellect/cognitive deficits on competence.

CONCLUSION

In conclusion, the following suggestions are offered to assist clinicians with evaluations of defendants for whom a disposition of unrestorable is at issue and represent a summary of some of the concepts presented above. These are offered only as suggestions and to stimulate thinking about the potentially unrestorable defendant. Each case should be approached individually.

1. The most frequently reported amount of time until a defendant was opined to be unrestorable was about one year. Given this, if a defendant has been in restoration status for over one year, remains incompetent with no improvement and different means of attempted restoration appear to have been exhausted, if not already evaluated as possibly unrestorable, assessment to determine if the defendant could be unrestorable might be considered. For the developmentally disabled/demented/severely cognitively impaired defendant, the time until a determination as unrestorable may be less.
2. Knowledge of the laws that govern lengths of time that defendants can be held in a facility for restoration is important. Are there specific categories of crimes that limit the amount of time a defendant may remain hospitalized for restoration? States vary widely on this issue.
3. The frequency of defendants found to be unrestorable appears to be, on the average, around 10% of restoration cases. A comparison of a facility's percentage of defendants found unrestorable with this statistic may stimulate thinking about the criteria used to determine if a defendant is unrestorable.

4. The length of time from the beginning of efforts toward restoration to the determination that a defendant is not likely to be restored to competence in the foreseeable future was, on the average, generally longer than the length of time needed for restoration to competence. Our experience has been that the courts generally (especially with more serious cases, e.g., murder) want to be assured that a sufficient attempt was made to restore to competence prior to adjudication as unrestorable, even when the defendant exhibited extended and significant intellectual/organic impairment. Defendants with refractory psychosis may need several trials of different medications and/or attempts at different forms of restoration education/therapy in order to demonstrate that further efforts at restoration will likely not be successful.

5. Because the courts generally require a dispositional recommendation along with an opinion of unrestorable, i.e., release, commit as mentally ill or certify as developmentally disabled, assessment for potential risk of harm to self/others and the ability to care for oneself, seems warranted or may be required. Such information is needed to support recommendations for post-adjudication care. Consequently, once an evaluating clinician believes that the defendant is unrestorable, additional time may be needed to adequately assess risk and make recommendations based on this assessment.

6. The length of time until a determination of unrestorable is made is an individualized decision which takes into consideration the context of the case, to include the crime, clinical presentation and whether or not the subject has shown any improvement toward restoration. Whether or not, and in which manner, the defendant has responded to treatment in the past can also be a factor to consider.

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AN APPROACH TO COMPETENCY RESTORATION

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This article presents an approach to restoration to competency to stand trial to include, but not limited to, 1) a pretrial forensic evaluation team that focuses primarily on competency assessment of restoration cases, 2) the assignment of a "restoration therapist" to all restoration cases, 3) ongoing feedback between the restoration therapist and evaluator, and 4) diverting defendants to outpatient evaluators when hospitalization is not indicated. Other policies/procedures are described which were developed to expedite and enhance restoration.

Due process, to include a speedy trial, is a longstanding principle of the United States' system of justice. In *Jackson v. Indiana* (1), the court found that a defendant "charged by a state with a criminal offense, who is committed solely on the account of his capacity to proceed to trial, cannot be held more than a reasonable period of time necessary to determine whether there is a substantial probability he will attain that capacity in the foreseeable future. If it is determined that this is not the case, then the State must either institute customary civil commitment procedures that would be required to commit indefinitely any other citizen or release the defendant." To restore a defendant to competence as soon as reasonable seems both legally and morally sound and avoids the inappropriate utilization of laws that govern the restoration of incompetent defendants for purposes other than intended, e.g., to remove a problem person from the public or correctional setting (2-4). Some states place a ceiling on the amount of time a defendant can be detained in restoration status (3, 5, 6). Differences in state laws governing restoration aside, few would likely disagree that timely and efficient restoration is in the best interest of the defendant, the court and the public.

Program designs are often clinically based; that is, they frequently are described in terms of clinical interventions, treatment models, and therapeutic techniques. Several programs promote, or suggest, specialized clinical methods for restoration (7-16). Sound clinical programming is as vital to restoration to competency as it is to clinical intervention in general. The de-

gree of progress for individual cases is generally assessed at regular intervals, which are often determined by legislated time mandates in the state in which the defendant is to be adjudicated if found to be restored. Reporting criteria mandated by law and general treatment team reviews may provide some structure for services and, if appropriately integrated into treatment programming, can enhance restoration. However, the contribution to restoration may be varied and, in some cases, minimal. A consistent procedural framework which includes specific assignments of duties along with regular and frequent re-evaluation of defendants beyond that which is required by law or general hospital policy promotes quality restoration services and can lessen length of stay, expediting due process and freeing up hospital beds—a cost effective outcome involving a valuable resource. Presented below are some suggestions for restoration to competency to stand trial with a discussion of their relevance to the restoration process.[1]

COMPETENCY RESTORATION

A Forensic Evaluation Team

As an outgrowth of recommendations made by the United States Department of Justice and agreed on by the then Department of Mental Health, Mental Retardation and Substance Abuse Services (currently the Department of Behavioral Health and Developmental Services) in the Commonwealth of Virginia (17), a Forensic Evaluation Team (to perform pretrial court ordered assessments only) was created. Psychiatrists and psychologists who possess expertise in pretrial court ordered evaluations (generally competency to stand trial and sanity at the time of the alleged offense) form the Forensic Evaluation Team, along with a clinical social worker and clerical support staff. This team functions independently from teams that provide treatment to restoration cases. This is thought to be sound practice, primarily promoting the avoidance of conflict of interest and conforming to professional ethics. The American Psychology Law Society Ethical Guidelines as well as those promulgated by the American Academy of Psychiatry and the Law indicate that mental health professionals who provide restoration treatment should

[1] The policies and procedures presented were developed and implemented by the Forensic Program of Central State Hospital, P.O. Box 4030, Petersburg, Virginia 23803, the maximum security facility of the Department of Behavioral Health and Developmental Services in the Commonwealth of Virginia.

not, whenever possible, also provide evaluation services to the same individual (18, 19). By separating the task of evaluation of competence to stand trial from those persons providing treatment, at least some of the biases that could be introduced by the dual role of evaluator/treatment provider should be diminished. One such potential bias is the need to see one's own patient as improved. Also, some studies indicate that competency evaluations may be skewed in a direction such that defendants who would otherwise have no avenue to treatment would be able to receive treatment under the disguise of incompetence (20, 21), supporting further the appropriateness of separating competency assessment from treatment.

Currently, the Forensic Evaluation Team at Central State Hospital in Petersburg, Virginia consists of four members, one of whom is a supervisor with 50% of time dedicated to evaluation and 50% to administrative duties. Two of the four perform evaluations only and the fourth member, a clinical social worker, is primarily responsible for acquiring information to assist in completing the evaluations and the diversion of evaluation cases that do not require hospitalization. Members of the Forensic Evaluation Team focus solely on forensic specific assessments as their job function and should be well versed on the criteria for competency to stand trial cited in statute (22), case law (23-31) and the literature for competency to stand trial (29-31). Also, these individuals should be skillful in report writing and understand that their consumers are primarily court officials. Forensic Evaluation Team evaluators should be experienced as expert witnesses and have the interpersonal presence to provide quality court testimony and consultation to court officials. The existence of an evaluation team allows for its members to develop relationships with one another, which are not only consultative and educational, but supportive and collegial. Before being sent to the courts, all reports produced by the Forensic Evaluation Team are reviewed by a co-team member and by the facility's Forensic Coordinator with individual feedback provided to the author of the report. This procedure provides an important check on the product produced by the hospital for the courts, and helps to ensure that the competency evaluation is of a high quality and conforms to mandated legislative criteria. Prior to the inception of the Forensic Evaluation Team, treatment team members would evaluate those defendants assigned to their own teams. Not only did this create a conflict of interest as

described above, but also spawned conflicts between team members who sometimes had differences of opinions about a particular defendant's competence. With the implementation of a forensic evaluation team, another seemingly positive outcome is that treatment efforts were no longer interrupted by a team member's absence from treatment responsibilities in order to perform court ordered evaluations and to prepare for and testify in court.

A full-time clinical social worker is assigned to the Forensic Evaluation Team. This person's primary job entails collecting information relevant to completing evaluations and sharing this information with the assigned evaluator, preferably prior to the defendant's admission. The evaluator may ask the clinical social worker to attempt to obtain almost any information he/she believes is relevant to the assessment. This obviously saves the evaluator time and allows the evaluator to focus more directly on the competency assessment process. The clinical social worker is also responsible for diverting cases that can be evaluated on an outpatient basis. Diversion of cases generally involves defendants who have been court ordered for evaluations that may not require hospitalization and inpatient treatment, such as those referred solely for evaluation for competency to stand trial and/or sanity at the time of the offense. Clerical support is provided with responsibility for, among other things, a tracking system/database to assure court and other deadlines are met.

The Assignment of a Restoration Therapist

Each defendant admitted to the hospital for restoration to competency to stand trial is assigned a restoration therapist who is usually a member of the defendant's treatment team. This staff member generally holds a doctoral degree in psychology, although a member of any discipline in mental health which provides advanced training at the master's level or above could meet educational criteria to be a restoration therapist. Restoration therapists have training in counseling and therapeutic interventions, as well as in the assessment of strengths and weaknesses, particularly those strengths and weaknesses related to competency to stand trial. They are trained in the development of intervention strategies for behavioral change, including motivating behavior. These staff members should also have specific training with a forensic population to include assessment and treatment and should have acquired a good understanding of the criteria used for competency to stand

trial. Restoration therapists sometimes observe evaluators from the Forensic Evaluation Team perform competency evaluations to gain perspective on which competency domains may require therapeutic focus. Restoration therapists should also be cognizant of the role secondary gain (to include malingering) can play in competency restoration.

Restoration therapists meet with defendants on a frequent and individual basis. Treatment objectives are determined by the restoration therapist in consultation with the assigned evaluator from the Forensic Evaluation Team and the defendant's treatment team. Participation by the defendant is encouraged whenever possible, although some defendants may lack the motivation/capacity to participate (e.g., malingering, uncooperative, acutely psychotic). Restoration therapists not only provide individual restoration services to the defendant, but also monitor the interaction of the defendant with staff and other patients. This latter source of information can be extremely helpful, especially when a defendant is not cooperative with formal assessment/treatment efforts or is thought to be malingering. Restoration therapists are aware of the functioning of the defendant in many different settings and circumstances in the hospital and not only in structured treatment activities. They consult with the Forensic Evaluation Team evaluator concerning specific areas of focus for treatment and the relevant deficiencies which, in the evaluator's opinion, contribute to the defendant's incompetence. Restoration therapists also provide assistance with coordination of treatment services for defendants and they provide feedback to the treatment team about the defendants. The restoration therapist may monitor the effectiveness of medication, particularly as it specifically relates to improving competency to stand trial. These individuals should have first-hand knowledge of the defendant's functioning relevant to competency, and when they are of the opinion an individual has been restored, they immediately contact the evaluation team to request assessment. In this manner, the defendant can be examined as soon as possible and avoid waiting for predetermined dates to assess, which are often established by statute or court order.

Restoration therapists consult with the Forensic Evaluation Team evaluators about defendants they have in common on their caseloads. Forensic Evaluation Team evaluators provide detailed information to the restoration therapists about defendants' deficits in specific areas of competence so that

restoration therapists can focus on those areas of functioning in their individual sessions and treatment planning. This information is shared with the treatment team psychiatrist, particularly when deficits involve a thought disorder, agitation or a mood problem which may benefit from the adjustment or implementation of medication. One of the primary objectives of the restoration therapist is to provide information to the evaluator about the defendant's functioning in areas that are parallel to those areas related to competency to stand trial, e.g., the defendant's capacity to communicate effectively and advocate for self, important components of competency to stand trial. Ability in these parallel areas of functioning could be demonstrated by, for example, the defendant's written request to the dietitian for specific items to be added to his/her diet or by seeking medication. Such observations not only demonstrate the ability of the defendant to advocate for self but also demonstrate the defendant's understanding of the different roles of staff members, and therefore indicate that the defendant can likely understand the roles of different courtroom personnel. Although little could be found about the concept of a "restoration therapist," some evidence exists for the value of assigning individual therapist/counselors to incompetent defendants (8).

Forensic Evaluation Team Required Interim Assessments/Reviews

While defendants can be examined for restoration progress any time after admission and whenever a staff member believes the defendant has been restored to competence, assessing at regularly scheduled intervals (beyond those that are mandated by the courts and/or by hospital policy/team review) is required to assure that those defendants who have achieved competence are not overlooked and are returned for adjudication as soon as possible. Independent assessment by the Forensic Evaluation Team offers advantages to the restoration process beyond simply attempting to determine if a defendant has become competent while striving to avoid conflict of interest. Frequent evaluation of the defendant's functioning by a resource outside of the treating team's review process can stimulate and redirect, if indicated, restoration efforts.

Defendants who have been adjudicated as incompetent to stand trial and have been admitted for restoration are evaluated for competence to stand trial within the first 24 hours after admission to the facility or on the next business day after a weekend or holiday. Some defendants become competent be-

tween the time they are adjudicated as incompetent by the court and the time they are admitted to the hospital. This appears to be, at least partially, due to delays between the time an order for restoration is written and when the defendant is actually admitted, or begins treatment. Sometimes this delay can be lengthy depending on court processing and the availability of hospital beds. In addition, interviewing the defendant within 24 hours of admission can establish a baseline of functioning relevant to competency to stand trial. This baseline evaluation, along with collateral information, can help direct treatment and the information obtained can be used for comparative and other purposes when the defendant is restored [or not] or when legislated time sensitive reports are written to the courts.

Obviously, attention must be paid to legislated mandates for reporting at specific time intervals. In Virginia, a report of the defendant's progress toward restoration must be provided to the court whenever it is believed that the defendant has been restored to competence or is likely unrestorable in the foreseeable future, or, minimally, at six month intervals after admission (32). Evaluation on a more frequent basis and interim evaluations are desirable. An internal evaluation (not court or treatment team policy mandated) is required at least every three months after admission no matter the defendant's reported clinical status at that time. While no formal court report may be required unless the defendant is judged to be competent to stand trial or unrestorable, evaluators must keep an interim evaluation in the defendant's file and present their findings at weekly case status reviews. Defendants are also evaluated approximately one week prior to each court date. Frequently, defendants are admitted with a predetermined date for a docket call so the court can track the defendant's status and whereabouts. This most often does not constitute a competency hearing and no formal report is required by legislated requirement to the court at that time; however, we have found that a brief letter to the court indicating the defendant remains in restoration status has been appreciated by court officials and, in some cases, expected. The Forensic Evaluation Team's assessment of defendants prior to each court date also has the advantage that if the individual were to be found competent, the designated court date could potentially be used as a competency hearing date, avoiding a long delay in setting a future court date to review competency.

After six months of efforts toward restoration and a defendant is not yet restored or not yet determined to be unrestorable, a consultation review about the defendant's lack of progress is required. While this process is initiated by the Forensic Evaluation Team, the restoration therapist and the attending psychiatrist are asked to be involved as needed. Also the defendant's chart is reviewed and the defendant is interviewed if appropriate. Recommendations are made, which can involve a new approach, modification in treatment planning and/or a decision to provide a particular opinion to the court. Also, it may be appropriate at this interval to opine that the defendant is likely unrestorable if this is thought to be the case. As long as a defendant has been in restoration status for at least six months and has not been determined to be restored or unrestorable, monthly consultation reviews continue to address the defendant's progress. Overall, with the above reviews, restoration defendants are assessed, on the average, every thirty days by a Forensic Evaluation Team member.

Advancing Court Dates and Retaining Defendants Until Close To Time Of Hearing

The length of time between finding a defendant competent in the hospital and the date of the hearing to adjudicate as competent or not, can be considerable, allowing for an increased chance for regression and a return to incompetence. In order to address this issue, when a defendant is opined to be competent, attorneys are contacted and urged to move up court dates to avoid long stays in jail prior to hearings. Also, treatment teams have the option, when appropriate, to keep a defendant in the hospital until close to the court date. The need to retain a competent defendant close to the time of the court date is justified by the head of the treatment team to the Medical Director with support for the recommendation given by the Forensic Evaluation Team member providing the opinion to the court. To be able to advance court dates and keep defendants in the hospital close to the time of competency hearings can prevent deterioration while defendants wait in jail for hearings, reducing recidivism and bed utilization in the long run.

Diversion of Non-Restoration Evaluations and Focus on Restoration Cases

Many state mental health agencies, including those in Virginia, prefer that pretrial forensic evaluations be completed in the defendant's locality or

an outpatient basis whenever possible; often this includes in local jails. Doing so can avoid hospitalization as well as the wait to be admitted for an inpatient evaluation. Diverting evaluations from the hospital to the community supports the position that defendants should be provided services in their own locality to the extent possible. This can facilitate contact between defendants, their lawyers and the courts and expedite the judicial process. Persons involved are in close proximity to each other rather than in a county potentially hundreds of miles away from where the defendant would be hospitalized for evaluation. Community assessment can also facilitate testimony, e.g., by decreasing considerably the amount of travel time to court. Since the Forensic Evaluation Team is responsible for all pretrial assessments, diversions can be helpful to a restoration process because assessments such as sanity at the time of the offense, sex offender risk assessments, and presentencing evaluations can be highly time consuming. Emphasis is placed on diverting these potentially time consuming evaluations allowing more focus on restoration cases and the restoration process, not only decreasing length of stay but increasing the quality of evaluation. The clinical social worker on the Forensic Evaluation Team is charged with the responsibility of diverting evaluations that could be performed in the community. Information available on defendants who potentially could be diverted is gathered and evaluated to determine if diversion is clinically justified and if the defendant can remain outside of the hospital for evaluation or if inpatient assessment seems necessary.

The diversion process can be difficult to negotiate because it often requires a change in order by the court. This means a judge, who already signed an order, will likely be asked to sign another. We have found that some judges do not appreciate or agree with diverting to an outpatient evaluator after they have ordered inpatient assessment. In addition, the diversion process usually starts with the defense attorney who first must be located and then convinced that diversion is an appropriate alternative for the client. Rapport with court staff and knowledge of court processes is important to achieve diversion; therefore it is probably beneficial that one person (in our case, the clinical social worker) has been assigned this duty. While sometimes not popular with court officials, we have found diversion to be in the best interest of both the evaluation and restoration processes.

Database and Data Analysis

Current and accurate information (type of orders, correct jurisdictions and dates for court requirements) not only help avoid reporting errors such as missing due dates but also allows tracking for regular reassessments/reviews. Defendants may be admitted with unrealistic dates (not enough time to complete evaluations), or incorrect dates for completion of evaluations for the court. Each time there is a hearing or docket call, dates may need to be changed as cases are continued and new dates set. Keeping track of this information requires a database that is as simple as possible, but still provides enough information to accurately track defendants, their court dates and reporting requirements. In our system, evaluators on the Forensic Evaluation Team are required to verify that the database is accurate for those individuals on their caseload. In reality, the duties for adding new admissions, moving discharged defendants to a different category and updating data (especially court due dates) in the database are those of clerical staff. The tracking system minimally includes the following information: name of the defendant, location in the hospital, referring court, type of evaluation requested, date of admission, date the order was written, date the order was received, court hearing date and the date the assessment/report is due to the court. Also included are dates of upcoming and regular reviews, the evaluator assigned, report completion date, and opinion/status (e.g., restored, remains incompetent, unrestorable). In addition, space is allowed for additional comments and clarification for each defendant. This information is used for utilization review and to justify services.

Standardization of Evaluation Criteria

The criteria established by *Dusky v. U.S.* (23) for competency to stand trial are relatively broad as are statutory guidelines (state laws) defining competency. Adopting standard criteria to define areas of competence seems important although considerable variation in criteria exists. Several authors have offered specific criteria for competency evaluation beyond *Dusky*. For example, McGarry (29) provides four general domains of competence. Grisso (31) presents a concise but useful description of competence criteria. Skeem and Golding (30) go into more detail, describing several criteria for competence. No matter what set of specific criteria beyond *Dusky* (23) are utilized, it seems reasonable to seek consistency with acceptable standards

and to ensure that restoring treatment providers and evaluators are aware of these standards such that they are working toward the same goals in competency restoration and can agree (to the extent possible) on the criteria for determining progress toward competence. However, differences among defendants, their individual cases and the courts can present different contexts that require flexibility in application of any set of standards.

Consultations with Attorneys

The amount of consultation (if any) that an evaluator should have with the attorney for the defendant or the prosecution is variable and depends on the specifics of each case. Often consultation with attorneys can be helpful for several reasons. Attorneys can sometimes provide useful information as to the reasoning behind the court's finding of incompetence, which can assist in focusing the restoration process. Observation of attorneys (with permission) interacting with their clients can also be helpful, not only allowing for an in-vivo analysis of client/attorney communication and the capacity of the defendant to assist in his or her defense, but may also aid in establishing rapport between client and attorney and help prepare the defendant for the legal process he/she faces. At the time of the discussion between the attorney and the Forensic Evaluation Team member, anything about the defendant's presentation that may raise questions relevant to competence can be addressed and placed in context. For example, consultation could help the attorney understand how the defendant, while delusional, can still be competent. The evaluator is cautioned that whatever is said could be introduced as evidence during court proceedings and in some cases interaction with attorneys should be limited or not take place at all. Informing defense attorneys when a defendant has been restored to competency and the defendant is to be returned to jail seems to be well received. Attorneys seem to appreciate the "heads up" and the evaluator's impression of the defendant prior to the defendant's return and prior to receiving a written evaluation.

Assessing Effectiveness

Effectiveness of specific clinical modalities/techniques is not within the scope of this article, although some positive correlation and overlap certainly exists between clinical effectiveness (in this case progress toward restoration) and the policies and procedures that govern restoration. Simply counting reviews/assessments to see that they actually take place at scheduled

times is suggested and as indicated above, enhances the probability of timeliness of reports to the courts, review of treatment, and finding that a defendant has become competent. One outcome measure for restoration to competency is the amount of time (in days) between the defendant's admission for restoration and when the defendant is considered restored. This seems important to due process, i.e., speedy trial (4) and is relevant to the issue of lack of resources (bed space). In our facility, the average length of stay for restoration (LOSR) defendants measured over a period of one year was 73 days (33) and compares favorably to other findings (34–41). Also found was a wide and varied dispersion of LOSR (1 to 560 days); this makes the use of measures of central tendency questionable because of the flatness of the distribution of different lengths of stay. With this type of distribution, to suggest that a mean, mode or median represents a typical length of time in restoration could be misleading. Probably more useful is to measure the number of cases that were opined as restored or unrestorable in a specific period of time. In our facility, 27% of the defendants with orders for restoration were either restored or opined unrestorable within a period of 30 days, 48% within 60 days, and 89% within 180 days. Less than 2% were in restoration status longer than 1 year. Collecting, periodically, follow-up data on how often defendants opined as competent are actually found to be so by the courts could provide some insight into restoration effectiveness, at least in the eyes of the court.

Comparison of effectiveness across systems (inter-program) has problems. Many factors which can impact outcome measures for competence to stand trial are difficult, if not impossible, to hold constant for comparison purposes. These include, but are not limited to, differences in clinical programming, competency criteria, defendant samples, legislatively mandated time criteria and the court's own view of competence. Pressures to free up hospital beds may be another factor. Extreme deviations can have a significant impact on length of stay and other data. Mueller et al. (38) found that 75% of defendants were restored in approximately five months. When extreme deviations were removed, time to restoration was reduced to 140 days, or slightly less than four months.

Cost effectiveness is a consideration. Existing staffing levels were used to develop the Forensic Evaluation Team and to assign restoration therapists.

This required a realignment of services to focus more on restoration with centralized assessment. As indicated above, treatment teams are then not responsible for evaluations and testimony for cases involving pretrial forensic defendants, which allows them to focus more on restoration treatment and the treatment of patients admitted for reasons other than restoration. Policies and procedures that promote efficient and effective restoration services are probably cost effective, not only in terms of the delivery of services, but because more defendants are likely to achieve competence and remain competent until adjudication. A positive byproduct is that lengths of stay are likely shortened, reducing waiting times for new restorations cases or other persons that require inpatient services; this would seem to reduce cost in the long run.

CONCLUSION

Ideas are presented for services to promote restoration to competency to stand trial. Specialized evaluators (Forensic Evaluation Team) conduct assessments separate from treatment teams and "restoration therapists" are assigned to each defendant. Diversion of non-restoration treatment cases to community evaluators, when clinically indicated, seems appropriate and can preserve resources to enhance restoration services. A current and accurate client database and time criteria for frequent and regular reviews (beyond treatment team reviews and those mandated by statute and the courts) seem to facilitate the restoration process. Competency to restoration is a complicated issue which can be affected by many factors, e.g., mandated time limitations for restoration, different thresholds for competency restoration, and variations in clinical programming. We hope that the above information will stimulate thought and provide ideas that assist others in the process of restoring defendants to competency to stand trial.

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COMPETENCY TO STAND TRIAL AND THE PARANOID SPECTRUM

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Criminal defendants with paranoid disorders are frequently referred by the courts for evaluation of competency to stand trial. While these defendants share with other psychologically-based referrals potential difficulty rationally understanding the proceedings, they also present unique challenges for the psychologist who must accurately assess their capacity to reasonably consult with their attorneys in developing a defense. Since mistrust and unwillingness to relinquish control are hallmarks of this diagnostic spectrum, it becomes crucial to ascertain the extent to which the essential collaborative aspect of competency can be met. This article presents evaluation scenarios with defendants diagnosed with delusional disorder, paranoid schizophrenia, and paranoid personality disorder; identifies issues likely to be encountered with each condition; and explores evaluation strategies and outcomes.

Frequently referred for competency to stand trial evaluations are those individuals who present difficulties for their attorneys due to undue and persistent suspiciousness, distrust, argumentativeness, and inability to collaborate. The impairment in attorney-client communication may range from grossly psychotic distortions, such as the defendant viewing his legal counsel as an alien in human form, through less bizarre but still delusional beliefs that the attorney is a participant in a conspiracy within the judicial system to deprive the defendant of his rights and "railroad" him, to chronic or transient unwillingness to rationally and cooperatively assist his representative in the development of a reasonable strategy to cope with pending charges. These individuals are usually diagnosed along the paranoid spectrum of disorders, and can present unique challenges for the psychologist assigned to evaluate the defendant and provide an opinion to the court as to whether he or she meets the standard for competency. The

Dusky standard (1), for example, requires the defendant to manifest both "sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding" and a "rational as well as a factual understanding of the proceedings against him." Paranoid disorders can impair either or both of these functions.

Although the relevant diagnostic categories involving paranoid ideation are capable of shading and blending into each other contingent on such factors as degree of felt stress, whether appropriate medication has been administered, changes in legal circumstance, and malingering, it is worthwhile to clarify distinctions between them, as well as the accompanying implications for the evaluator's task. The ultimate opinion as to whether the defendant is capable of competently standing trial or entering a plea rests largely on the evaluator's ability to place the defendant's symptom presentation into an understandable forensic perspective. Although in a number of cases the findings would be clear and unequivocal, in others the issues are likely to be quite murky.

This article has as its purpose to review the DSM-IV criteria (2) for the major diagnoses of paranoid manifestations, and the corresponding implications for the issue of competency to stand trial. While paranoid symptoms may appear in the context of a range of disorders, such as major depression with psychotic features, dementia with delusions, or delusional thinking secondary to substance abuse, the focus herein will be limited to the most commonly encountered conditions requiring forensic assessment. Case examples are provided to highlight the legal implications of defendants with either schizophrenic disorder, paranoid type, delusional disorder, or paranoid personality disorder.

SCHIZOPHRENIC DISORDER, PARANOID TYPE

This condition is, of course, first and foremost a schizophrenic disorder and as such shares signs and symptoms with other subtypes of schizophrenia. Hallmarks of the paranoid subtype are bizarre delusions and auditory hallucinations. Bizarreness may be difficult at times to ascertain,

particularly taking into account the generally accepted existence of many personal, cultural, or subcultural beliefs that defy reality, are not on their face comprehensible, and are essentially "fixed." However, the definition is usually satisfied by beliefs that are clearly implausible, blatantly unreasonable, and unable to be understood from the perspective of normal human experience. Persecutory delusions and auditory hallucinations are considered to be the most likely of the respective types of these symptoms, in comparison with, for example, somatic delusions or olfactory hallucinations. If the delusions are deemed bizarre or the auditory hallucinations involve running commentaries on a patient's thoughts (or involve multiple voices conversing), no other criteria need be present to diagnose schizophrenia. Paranoid schizophrenia can be distinguished from other subtypes of the disorder by the absences of disorganized speech, catatonic or disorganized behavior, or negative symptoms such as flattened affect or avolition.

While individuals who typically meet the criteria for the paranoid subtype of schizophrenia tend to be outspoken and florid in communicating their beliefs and experiences, this examiner has observed a rarer subcategory, whose beliefs are very privately held, emerging only in exceptional circumstances, such as periods of extreme stress or sleep deprivation. Defendants with such closely guarded delusional beliefs or hallucinatory experiences are frequently not detected during routine psychological evaluations, and are more likely to be identified by chance.

Two cases of paranoid schizophrenia are presented to illustrate variance in degree of transparency/opacity of such psychotic processes, with accompanying implications for competency to stand trial.

Margaret W

This forty-nine-year-old divorced white female was facing charges of arson and assault I (attempted murder) after setting fire to her apartment. The fire spread, consuming a number of units in her building, resulting in significant property damage, as well as serious injury to twelve inhabitants

of the complex. Margaret had an extensive psychiatric history, including numerous hospitalizations, typically for blatantly psychotic behavior, with persecutory or grandiose delusions. For the month preceding the incident in question, she had reportedly been noncompliant with her medication and was described as having become progressively more suspicious, reclusive, and belligerent. She had been referred by the court for a competency evaluation after her attorney found that she was unable to interact in any type of realistic, coherent manner with him, insisting that she had been ordered by "The Lord of the Dance" to set fire to her dwelling in order to "purify the bleeding premises." Margaret maintained that the purpose of her behavior was to remove unwanted spirits and demons which had seeped in through the vent in her kitchen. Since being incarcerated, she had not received medication and was thus continuing in her psychotic mode when first encountered by the examiner.

During the interview, she responded obliquely to questions, manifested a haughty demeanor, avoided eye contact, and occasionally conversed smilingly with something near the ceiling. A report forwarded to the court following the interview described her demeanor as that of a classic schizophrenic disorder, paranoid type, in an acute phase of disturbance, and conveyed an opinion that she was not competent at present to stand trial. She certainly would have been unable to meet either prong of the Dusky standard. Since her records indicated, however, that she historically had reintegrated rapidly when administered medication, the examiner expressed that she would likely attain competency in the foreseeable future with appropriate treatment, and thus recommended chemotherapy and a follow-up evaluation.

Indeed, a second visit several weeks after medicine was initiated found the defendant in a subdued mood, in good contact with reality, aware of her circumstances, appropriately remorseful, and fully able to interact rationally. Her delusional beliefs and command hallucinations were now completely in remission. A formal psychological evaluation was now able to be conducted, the results supporting the observational data that her

thinking was now rational, efficient, without significant distortion. Margaret's ability to work with her attorney and to understand the proceedings was now sufficient for her to be considered competent. The examiner expressed the opinion that she was very likely to remain stable as long as she remained compliant with her treatment.

Tyrone L

This twenty-nine-year-old married black male was charged with numerous counts of assault, perpetrated on his three stepchildren, ranging in age from three to seven. The abuse had been described as quite severe, consisting of savage beatings of each of them, all occurring within a several-minute block of time. The case had garnered considerable notoriety in the local media due to the extent of injuries to the children. Mr. L had been routinely ordered by the court to be evaluated for both competency and criminal responsibility (insanity), although his attorney had noted no impairment in the defendant's understanding of his legal circumstances, and found him to be a cooperative, reasonable man with whom to work.

The psychological evaluation of this defendant was uneventful until late in the second session of data collection. He had been fully cooperative, exhibited appropriate remorse for the events with which he was charged, clearly understood the seriousness of his circumstances, and had demonstrated reasonable sophistication in his understanding of legal concepts, strategies, and procedures. Psychological testing had uncovered no reason to believe that he was other than fully competent. Intellectual functioning was measured to be in the normal range, no organic issues were present, and no evidence of a psychiatric treatment history had been found. Reality contact was, as far as could be ascertained, without impairment. To further explore his capacity to produce realistic perceptions, with adequate justification, the examiner administered the Rorschach test. Although his form quality and content were unremarkable, ranging from ordinary to superior (3), with many Populars, and his balance of determinants was in no way a matter of significant concern, Mr. L's response to

Card IX dramatically altered the findings of the evaluation. Commenting on the pink area at the bottom of this card (D6), the defendant uttered, almost as an aside, that it "looked like the Wooloos." Inquiry into the meaning of this term led into a realm of fantasy harbored by the defendant which had never previously been expressed to any living individual. As he elaborated, it became apparent that Tyrone maintained a delusional belief in a hidden reality containing a range of creatures, some of which represented a threat to his life. Actually, while discussing the "Wooloos" as if they did exist, he was also aware that consensual validation for this would not be possible to obtain, and thus the creatures were a matter of personal, private creation. While his beliefs in this regard were usually dormant, a period of three days in which he had slept minimally or not at all had brought them to the fore. Once at the center of his consciousness, he was unable to maintain control over the intensity of the fear that accompanied the creatures. Further investigation revealed that the abuse had transpired due to his misperception of the stepchildren as "Wooloos" and subsequent violent reaction to the threat that he believed existed. The description of his perceptions, provided in a distant, subdued, lifeless manner, helped make understandable what otherwise had been inexplicable, as his wife had repeatedly portrayed Tyrone as a warm, loving spouse and parent.

Irrespective of the obvious implications for the issue of insanity, the examiner was faced with the thorny question of whether a defendant possessing a bizarre, but hidden, delusional system could meet the criteria for competency. In essence, would his deeply held, unrealistic beliefs disqualify him from collaborating with his attorney (which had not thus far been a problem) or substantially compromise his understanding of the proceedings against him (which had not appeared to have been the case, either with the examiner or his attorney)? After additional consultation with the defendant, and considerable deliberation, placing the delusional thinking in the broader perspective of the whole of Tyrone's life to the present time, the potential of substantial disruption or distortion did not

seem to the examiner to be sufficiently likely to warrant an opinion of incompetence. This conclusion was proffered to the court and accepted.

To summarize with regard to schizophrenia, paranoid type, an individual in an acute state with classic symptoms is likely to be unequivocally not competent. As a rule, though, medication is effective in allowing such defendants to eventually attain stability, rationality, and thus, competence. With regard to the less classical, rarer, closely guarded presentation, the findings are less certain. Relevant considerations would be the incidence of "breakthroughs," the sensitivity to stress of such defendants, and perhaps the nature of the delusional focus. This author wonders how many of this latter type are never identified in the course of forensic evaluations.

DELUSIONAL DISORDER

Essential to the diagnosis of delusional disorder is that the beliefs or delusions are not bizarre, and the patient can often provide a web of evidence to superficially support his or her claims of being followed, betrayed, exploited, or persecuted. In fact, much of the sufferer's existence is designed to accumulate "proof" that his view of what is occurring is realistic. The aspects of Criterion A for schizophrenia (hallucinations, disorganization, negative symptoms, bizarre delusions) must have never been met, superficial adaptive functioning is often not markedly impaired, and behavior is not obviously odd. Thus, an individual with this diagnosis would likely avoid drawing excessive attention or being easily identifiable. It would not be uncommon for someone with a delusional disorder to be able to maintain employment (although the more isolated the better), to belong to professional or social organizations, manage his daily affairs, and perhaps even establish a semblance of a marital or family situation. Only a close encounter with such a person would reveal the pervasive irrationality and rigidity of his thinking, as well as the potential threat he might present to the focus of his anger and/or fear. What, of course, renders the individual psychotic is the fact that his beliefs cannot be supported by objective reality. His alleged victimization and implicit special-

ness is a matter of his own doing, created and maintained to allow for ongoing justification of the existential stance he has learned.

If the delusional system is intact, but focused on issues external to the legal circumstances, an individual with a delusional disorder might conceivably meet the standard for competency to stand trial. A frequent occurrence found in defendants with this diagnosis, however, is the tendency to incorporate aspects of the judicial system, including the defense attorney, into the pseudo-community (4), the purposeful, unified social fabric created by the defendant. Thus, the defense counsel, particularly if appointed, is often seen as either a dupe or a willing participant in a vast, surreptitious plot to find guilt. Rather than aiding or serving the patient, the attorney is perceived as an integral part of a sham process. Consequently, the defendant may insist on serving as his own attorney, or may refuse to collaborate with his counsel. Individuals with this diagnosis are classically described as articulate, intelligent, and forceful in presenting a point of view. They are also typically not responsive to persuasion or offers of treatment, claiming that they do not need it, and construing efforts to medicate as yet another facet of the devious conspiracy to deprive one of his rights and do him in.

Two cases of individuals with delusional disorder are presented to highlight varying implications for competency, depending on the focus of the perceived threat.

Walter B

According to relatives contacted as part of the effort to obtain background information, this successful fifty-six-year-old realtor had always been a controlling, difficult, suspicious, argumentative person, perhaps with a paranoid personality disorder. His daughter, for example, recounted that she was not allowed to date or wear makeup while living in his home.

gave a quite similar report of excessive control on his part. The defendant had been referred following the alleged murder of his second wife, who had been shot in the head while she slept, and who was believed by him to have been embezzling from his company's business account. Although all discovery material able to be reviewed strongly suggested that this woman was perhaps the only individual in his life that he could unequivocally trust, the defendant had become fixated on her as the source of his financial decline. His business associates, meanwhile, all of whom were male, completely escaped scrutiny or suspicion on his part, despite clear evidence of irresponsibility, and perhaps criminality, in their handling of his business while he was ill. Mrs. E was certainly the designated nemesis.

A serious physical illness occurring two years before the eventual murder seemed to play a significant role in precipitating the defendant's transition from a probable personality disorder to a psychosis, a delusional disorder. For the better part of a year, Walter was forced into a dependent, relatively vulnerable position for medical reasons, while his wife had been relegated to the role of primary caretaker. As he recovered, and resumed his characteristic hostile, suspicious stance, Walter became convinced that his wife had taken advantage of his previously weakened position and was the "shadowy" source of his economic misfortunes. Despite the fact that his associates had, at a minimum, engaged in some highly questionable, risky practices, no anger was directed their way. A striking finding of the evaluation was that this defendant very selectively focused his paranoia toward women, while managing to grant men of his acquaintance virtual total freedom from suspicion.

As might be predicted, Walter performed well on psychological testing. He scored in the superior range of intelligence on the Weschler Adult Intelligence Scale-Revised (WAIS-R), demonstrated clear awareness of the seriousness of his legal circumstances during the competency interview, had only one clinical scale even slightly in the significant range on the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and exhibited a high percentage of F+ responses on the Rorschach. His score on the

Whitaker Index of Schizophrenic Thinking (WIST) was also well within non-pathological limits. Only an occasional tendency to questionably associate disparate percepts on the Rorschach into larger wholes gave any suggestion of internal pressure to see connections which were difficult or impossible to realistically justify. Form quality deteriorated slightly on these forced Ws. On paper, however, he was essentially without pathology.

Unfortunately, the judge assigned to this case was female. Over the several sessions during which the examiner saw the defendant, it became increasingly obvious that Walter had shifted the responsibility for his decline from his deceased wife to the judge. Virtually every waking moment in the jail was spent researching her previous rulings, by gender of defendant. Each time he was visited by either the examiner or his attorney, Walter presented additional ammunition supporting his belief that he could not receive a fair hearing or trial from the "robed harpy," as he referred to her. He contended that he now possessed clear evidence of a bias against males on her part. Speaking in an intense, earnest manner, he assured everyone who would listen that the judge had "assumed the mantle" previously maintained by his deceased wife, and was motivated by a strong desire to "revenge the sisterhood." Mr. E's attorney had attempted to confront him more aggressively regarding the necessity to rationally deal with the issues at hand, and as a result, despite Walter's predilection to spare males his suspicion and wrath, had begun to regard and refer to his counsel as "her acolyte."

The gender issue, as a factor in the defendant's delusional disorder, was noted in the report to the court. It was the examiner's opinion that Walter did not presently meet the standard for competency, as his delusional system now encompassed officers of the court, impairing his capacity to rationally grasp the proceedings or work constructively with his attorney in developing a defense. Although the report recommended considering a transfer of the case to a male judge, this was not granted by the court. The judge did rule that he was not competent to stand trial, and or-

dered him to be held in a forensic treatment facility. Despite attempts to provide medication to him, Walter steadfastly refused treatment of any kind, and persisted with his mission of convincing others that he had been victimized by the system. Although scheduled to receive periodic assessment of his status with regard to competency, he has rigidly maintained his typically aloof, suspicious stance. The probability that he will eventually meet the Dusky standard is now very small.

Thaddeus R

Thaddeus and his long-time friend Michael were highly respected members of the African-American community. Together they had managed to obtain a government grant to establish a neighborhood center where youths could spend constructive time. They had enlisted numerous volunteers to assist with remedial education, arts and crafts, sports and vocational training. As part of their commitment to promote respect for the law and for the rights of others, representatives of law enforcement, mental health, and religious groups also gave their time. Michael and Thaddeus also taught a joint Bible study course, required of all participants in the center's programs.

Much earlier in Thaddeus' life, he had spent time in prison, and had twice been required by the court to attend anger management counseling, related to domestic conflict with his wife at the time. He had been divorced for a number of years, and for the past five years had lived quietly with his mother. Although a reasonably popular, and to some extent, honored figure among his acquaintances, Thaddeus maintained a distance, privately fearing, according to his mother, that no one could be trusted. He believed that he could easily be "set up" for a return to prison. Michael for a time was a significant exception to this, and the two men had forged a close working relationship.

This relationship, however, came to an abrupt end following a heated quarrel during their jointly-taught Bible course. The two men found themselves at odds over an obscure passage from Leviticus involving "strange

fice." The confrontation and disagreement deteriorated into mutual personal insults and accusations. Thaddeus believed that, because he had made the more pertinent, telling points, Michael would have been humiliated and would consequently wreak his own form of retribution by killing him. Thaddeus immediately withdrew from his activities at the center, gradually becoming even more reclusive, isolated from his previous limited social contacts. His mother later described him as spending his days in a darkened room, peering through blinds onto the street recording the comings and goings of pedestrians and autos that struck him as suspicious. Occasional cryptic references to "heathen vendettas" were expressed. He interrupted this monitoring only to take his mother to doctor's appointments, grudgingly running errands for her or, rarely, visiting a neighborhood fast-food restaurant. Whenever he left the house, he was heavily armed.

Observers of the inevitable denouement described a horrifying event. While Thaddeus was eating, Michael happened to enter the restaurant, oblivious to his presence. The entrance, however, was perceived as threatening, perhaps potentially lethal, to the defendant, who drew his weapon and sprayed the restaurant with bullets. Several witnesses reported that Thaddeus was screaming something to do with "the sons of Aaron" while he was firing. Although, miraculously, no one was killed, a number of customers, including Michael, sustained serious wounds. Property damage was extensive.

When Thaddeus was first encountered by the examiner, several months had passed. The discovery material and collateral interviews with family members and acquaintances clearly indicated the presence of a delusional disorder. Although the defendant continued to maintain a stance of vigilance and distance, the tension inherent in his delusional beliefs had by now largely abated. Thaddeus now realized that he had misinterpreted events subsequent to the disagreement over the Biblical passage, and although he was not willing to completely forego his stance of suspicious

ness, he had agreed to take medication. He was no longer actively delusional.

Testing was once again largely uneventful. The defendant demonstrated high intellectual ability, expressed realistic concern for his legal circumstances, and acknowledged his predisposition toward paranoia. His delusional system, now largely in remission, did not extend to, or incorporate, the judicial system. The opinion provided to the court was that the defendant was thus presently competent to proceed. After a hearing on the matter, the court agreed, and a trial date was set.

To summarize the effects on competency of a delusional disorder, the primary issues seem to be whether the delusional beliefs incorporate the defendant's attorney or judicial system, and whether the defendant is currently actively delusional, resisting treatment. It is possible for a defendant to be delusional regarding aspects of his life and still meet the standards for competency to stand trial, but, of course the probability of being competent increases exponentially if the symptoms are in relative remission. If the fixed beliefs extend to the proceedings or principals in the courtroom, it becomes unlikely that the defendant will be found competent, particularly if medication is rejected. Treatment tends to be more problematic with a delusional disorder than with paranoid schizophrenia.

PARANOID PERSONALITY DISORDER

A personality disorder is described in the DSM-IV as an enduring pattern of inner experience and behavior, deviating markedly from the expectations of the culture, and manifested in either cognitive, affective, or interpersonal functions, or in impulse control. The pattern is considered to be relatively inflexible, pervasive across situations, leading to clinically significant distress or impairment in important areas of functioning, and is of long-term duration.

A paranoid personality disorder is considered by Millon (5) to be a severe personality disorder (along with the borderline and schizotypal syndromes), and is described in the DSM-IV as a pervasive distrust and sus-

picion of others, such that their motives are interpreted as malevolent. Among the specific criteria for the disorder are a reluctance to confide, a tendency to see hidden meanings, a predisposition to bear grudges, suspicions of betrayal, and a preoccupation with unjustified doubts about loyalty of those close to him or her.

Although, unlike an individual with a delusional disorder, the sufferer with a paranoid personality disorder is considered to manifest no clear-cut or persistent delusional beliefs, it is also noted that stress can lead to psychotic episodes, and, in fact a paranoid personality disorder may be antecedent to a delusional disorder. Thus Millon refers to "mini-psychotic episodes" in which delusional thoughts are exhibited, and "mini-psychotic cognitions" in which events are distorted into personally meaningful and logical, but ultimately irrational belief systems. The inelasticity of coping skills is considered to justify its classification as "severe."

The overlap between the two conditions can lead to difficulties making a definitive diagnosis. A determination of whether the hostile ranting and pervasive suspicion of the patient is psychotic ("fixed" or "truly believed") or merely an expression of a chronic unease with collaboration and trust, and thus a chosen, expedient indulgence of a predisposition to be difficult, can be problematic to confidently make. Obviously, the distinction can have serious implications for the assessment of the defendant's competency. Collaboration, trust, disclosing personal information, and surrendering, even temporarily, control and self-sufficiency, for example, are essential elements in a productive relationship with one's attorney. The dread of relinquishing a degree of personal control must be confronted and overcome if one is to be effectively defended. While it is usually not possible for an individual with a delusional disorder to do so, one with a paranoid personality disorder may be able to see it as ultimately in his best interest and thus rise to the occasion, even if extremely painful.

Two cases of defendants diagnosed with a paranoid personality disorder are presented, along with accompanying scenarios for the assessment of competency to stand trial.

Albert A

This forty-three-year-old divorced white male was facing a range of mid-level charges which threatened to lead to a parole revocation and a return to incarceration in prison. An accumulation of minor thefts, traffic violations, alcohol offenses, and assaults were pending. Albert intensely disputed the validity and seriousness of the charges, meanwhile managing to feel righteously indignant about being victimized by "the system." He maintained that, in a previous case, he had been poorly represented by an attorney who had advised entering a guilty plea to a felony charge rather than going to trial to contest it.

He also claimed that police officers had been lying about him for years, and that a judge had miscalculated the length of a previous sentence. Any responsibility he might share in his state of affairs was conveniently ignored. The anger generated by his perceived victimization pervaded his thinking and impaired his capacity to trust and collaborate with his newly appointed public defender.

During the examiner's initial visit, Albert was briefly reasonably cooperative. After about a half-hour of accumulating background information, however, he declined to continue, citing his attorney's supervisor as having allegedly advised him to not disclose personal information. Despite the examiner's attempts to persuade him to continue, particularly pointing out that the court had ordered the evaluation at his attorney's behest, he would only reply guardedly that he was "not at liberty to discuss these matters," refusing to budge from his position.

This was conveyed to the court, which re-ordered the evaluation, with the addition that, in future contacts with him, Albert's attorney was to be present. The supervisor denied advising the defendant to not participate, Mr. A obviously having used an innocuous remark for his own purposes, distorting in the direction of maintaining an appearance of control and invulnerability.

During the second visit, Albert presented the examiner and his defense counsel with "documentation" to support his grievances with the judicial

system, the evidence contained in a stack of papers coded by color, containing illustrative graphs and figures, to clarify his history of alleged victimization. He claimed to be able to provide details, dates, and names corresponding to his complaints, while referring to federal and state case law to buttress his point of view. Any attempt by the examiner or defense counsel to challenge, question, or clarify was met with condescension and vituperation. He did not mind using the vilest of epithets toward either of us. The ranting lasted well more than an hour and showed no signs of abating. When confronted with the necessity of completing an evaluation, he once again resisted. Finally, the examiner, exhausted by the diatribe, informed Albert that he would be given one more opportunity to cooperate. If he did not show a good faith effort, he would be referred for an inpatient examination. His attorney agreed to research the case law he cited, as well as review the issues he raised with regard to his previous convictions, and a third session was scheduled a week hence.

Perhaps in part being mollified by the rage he had ventilated during the second visit, the defendant did present in a relatively pleasant, compliant, task-oriented manner. Obviously, he did not wish to be transferred into an inpatient facility, had weighed the options, and chose to participate more appropriately. This strongly suggested that, despite Albert's expressed pervasive mistrust and capacity for distortion, he was not psychotic. Despite his considerable investment in "proving" the conspiracy against him, he was actually demonstrating that he was fully capable of collaboration when he believed it to be in his best interest to do so. Expediency provided a simpler and clearer explanation for his behavior than did delusional thinking. An individual with a delusional disorder would have been much less likely to comply with the stated contingencies, more probably responding to the imposed limits as additional "grist for the mill," further reinforcing a perception of being aligned against. Albert, by behaving in what would be considered a reasonable way, exhibited more than a modicum of flexibility, adaptability, and rationality, qualities that would enable him to consult with his attorney and rationally understand the proceedings

against him. In essence, his compliance with the limits stated enhanced the likelihood of his meeting the standards for competency.

Psychological testing further supported the hypothesis of personality disorder, as opposed to delusional disorder. Although he participated grudgingly, no disorder of thought was detected in his Rorschach, WIST, or WAIS-R performances, and he clearly understood his legal situation. Although he was certainly capable of distorting or bending the facts in a self-serving way, his previous experience in the courtroom, together with his accumulation of data to support his point of view, identified Mr. A as a relatively sophisticated defendant. Only his ability to consult with his attorney could be questioned, and his decision to acquiesce with an "outpatient" evaluation aided in addressing this issue. It strongly indicated that he possessed more than sufficient capacity to cooperate in his defense when he believed it to be beneficial to him, an eminently rational position to take. His paranoid contentions and intense oppositionality could now be easily construed as a gratification of sadistic impulses, but not delusional in nature.

Eventually, the court ruled that he was competent to stand trial, a plea agreement was arranged that was satisfactory to all parties, including Albert, and he pleaded guilty. Before he could be sentenced, however, Albert was severely assaulted in the jail by another inmate, perhaps a function of his own hostile, provocative manner of relating. He sustained significant organic impairment as a result of the incident, resulting in a transferal to a hospital, then a nursing home. After an additional year of periodic evaluations and observations, it was apparent that the defendant no longer functioned at the level necessary to meet the criteria for competency, and would likely never regain it. The court revisited the issue, declared him not competent, and dismissed all charges.

Lee F

This forty-six-year-old divorced black male had not been found competent by the court in seven years, as of the time of this examiner's first

contact with him. He had been charged with a number of murders and assorted robberies occurring over a several week period, the victims typically being isolated, elderly men. By contrast, Lee was a robust, muscular military veteran who, at the time of the crimes, had recently qualified for Social Security Disability on psychiatric grounds. Although the psychiatric reports at the time tended to be vague, lacking in firm data, paranoid tendencies were noted, as well as poorly defined psychotic episodes.

Over the years, he had been considered to meet the criteria for competency by two separate state-employed psychiatrists, each of whom had seen him on an inpatient unit and thus had the opportunity to observe his interactions on a daily basis, in addition to acquiring extensive psychological and neurological evaluations, and conducting formal competency interviews. Each time the court ruled against these opinions, and in favor of those proffered by the defense experts (a psychiatrist and a forensic psychologist working together), who invariably described the defendant as a much "sicker" man, unable to assist in his defense or rationally understand the proceedings against him. While the independent psychiatrists typically diagnosed Lee as a paranoid personality disorder, the experts retained by the defense considered him to manifest a schizophrenic disorder, paranoid type. A vast amount of background information and numerous copies of previous evaluations were provided to this examiner when he was appointed by the court to examine the defendant.

Looking at the accumulated perspective of the defendant over time, several impressions stood out. First, the examiner found, at best, minimal evidence of bizarre delusions or hallucinations. Certainly, none had been observed in the inpatient setting. The defense experts had reported, relatively recently, that Mr. F. claimed to have witnessed a UFO landing on the lawn of the state hospital where he currently resided, but no other such experiences had been noted by anyone involved in the case. Earlier opinions of the defendant prior to his arrest were too equivocal and vague to be of value. The examiner came to the tentative belief, based on the record, that a schizophrenic diagnosis was not warranted and that the important

distinction would be whether he was delusional or personality disordered. Secondly, the defendant's behavior and verbalizations during formal assessments appeared to have been shaped, in iatrogenic fashion, by the questions posed and expectations subtly communicated, by the defense team. Despite receiving treatment on an inpatient unit for several years and interacting appropriately with both other residents and the staff, for the most part, he was portrayed by them in their reports as progressively more psychotic. Finally, it was obvious from the record that the defendant had for a time behaved disrespectfully toward his court-appointed public defenders, addressing them in personally demeaning ways, refusing to cooperate with them, "firing" them, and expressing disdain for their lack of effectiveness in protecting him from violations of his constitutional rights. Mr. F. had immersed himself in the legal aspects of the case, and had acquired a veneer of control and sophistication, utilizing appropriate terminology to justify his anger and unwillingness to submit to yet another evaluation.

The first several times this examiner met with the defendant, accompanied by both of his attorneys and the two defense experts, Lee refused to cooperate, typically stating "the court ordered me to present myself, so I'm presenting myself," at which point he would leave the room, not participating further.

Finally, on the fourth visit, he ostensibly agreed to allow himself to be evaluated. The result was predictably a hymn to malingering, a tour de force of poor effort. This individual, who had at least superficially mastered complex legal terminology and strategy, attained a Full Scale IQ of 62 on the WAIS-R. Throughout this test, he seized opportunities to rant about racial injustice, deprivation of due process, and violation of constitutional protections while allegedly being unable to define relatively simple words, such as "terminate" or "assemble." Despite his demonstrated ability to read and absorb very difficult forensic material, he would have one believe that he could not recognize or pronounce words at even a third grade level on the Reading Section of the Wide Range Achievement Test-

Revised (WRAT-R). The word "chin," for example was read as "chitlins," providing Lee with a convenient platform from which to expound on the racist nature of the evaluation process, pointing out that the five of us in the room with him were white, and were secretly in league to humiliate him, "an innocent black veteran who served his country in Vietnam." His insistence on venting tirades in the midst of the testing profoundly limited the efficacy of his performances on timed tasks, and he did not respond to personality testing in good faith, in essence treating the examiner with the same abusive oppositionality he routinely used with his lawyers.

Although the ensuing report informed the court that evidence for malingering was abundant, it also could not be authoritatively stated that the defendant was in fact competent. Since the court had ruled that the evaluator could not obtain information on the defendant's current treatment or day-to-day life in the psychiatric unit where he was a resident, the examiner was essentially limited to face-to-face data.

Time passed. Approximately a year later, the court asked once again that Lee be evaluated for competency. Nine years had now passed since the charges were originally incurred. On this occasion, the evaluator was accompanied by only one of Lee's attorneys and one of the experts. Lee encountered us in the vestibule of his unit and quickly informed us that he had no intention of cooperating. However, as the group resignedly sat down with him in this open area, Lee could not help but trumpet two "victories" he had recently experienced. Apparently, over the past several years, unbeknownst to myself, he had engaged an attorney of his own choosing and successfully sued the staff of a previous unit in which he had resided in the hospital. He produced a congratulatory letter from his attorney, displayed a copy of the judicial ruling, and was able to cite the foundations and precedents of his action. Furthermore, he had received back pay from a disability claim with the Veterans Administration, which he claimed made him "nigger rich." During the course of the regaling of his audience, he also took opportunities to comment incisively on my previous report, showing sections which he had highlighted, and expressing

particular pleasure over my comment involving "iatrogenic shaping." He obviously had no difficulty grasping and analyzing, even appreciating, issues of subtlety and complexity. The defendant, in his exuberance, invited us back to his room, where a copy of the disability check was framed and numerous bound volumes of legal journals were neatly stacked beside his bed.

On the basis of this ostensibly informal interview, lasting perhaps an hour and a half, the examiner was able to arrive at several conclusions relevant to the issue of competency. Certainly, it was now beyond question that the defendant had the necessary ability to rationally grasp the proceedings against him and to participate with an attorney, if he chose to do so. If there had been any argument as to whether he had been malingering during the formal testing, it was now unequivocally dispelled. It also had now been demonstrated that Mr. F could choose to collaborate when he perceived it to be in his best interest. Although the criterion for competency in the role of a criminal defendant demands more than it does for a person in the civil role of a plaintiff, he could not, with his obvious level of intelligence, persuasively argue that he could not understand the proceedings, and the inescapable fact was that his mental state or condition did not impair his involvement with his attorney in the lawsuit. Certainly the aggrieved role of plaintiff was a better fit for his style of accusation, attack, and revenge. Again, the issue of being able to make choices consistent with his best interests, setting aside suspicion and control when necessary, removed his functioning from the arena of persistent delusional thinking, and thus psychosis, to the more reality-based realm of mistrust, belligerence, and need for self-determination.

The examiner now felt comfortable concluding that Lee was competent to stand trial. Following the submission of the report, the judge, noting the defendant's enhanced financial circumstances, ruled that he was no longer entitled to publicly funded defense counsel, and ordered him to hire a private attorney. However, at the competency hearing following this ruling, Lee served as his own attorney, creating a surreal scenario of a

previously incompetent defendant arguing competently to be found incompetent. The court managed to wade through this forensic quagmire and ruled that, after nine years, he was now competent to stand trial.

To summarize with regard to individuals exhibiting a paranoid personality disorder, the challenges presented are, in the author's opinion, the most daunting of the three diagnostic entities addressed in this article, in terms of the psychologist's task in assessing competency to stand trial. In addition to being confronted with the endless wrath and manipulativeness of these defendants, it is often extremely arduous to separate them from those presenting with a delusional disorder. Many of their verbalizations and the intensity of their behavior are consistent with delusional thinking, and, in fact, the two conditions may be considered to overlap.

With regard to competency, the disorder strikes at the heart of what is necessary, the capacity to collaborate and relinquish control. One must continually confront the central issue of whether these defendants cannot do so, as is usually the case with truly delusional individuals, or whether they are merely gratifying a propensity to be suspicious. Personality-disordered subjects show relatively greater flexibility and capability of adjusting to environmental changes, particularly when the shifts are perceived as favorable. While the element of rational choice is admittedly diminished to varying degrees, the author contends that it is indeed present, albeit clouded by the volcanic anger and mistrust directed toward the examiner, which serves to distract one from recognizing the defendant's hidden comfort in the role of aggrieved victim.

More than likely, information from beyond the formal assessment will be needed to aid the evaluator in formulating necessary distinctions and arriving at an acceptable level of confidence in making an informed call.

SUMMARY

A number of potential scenarios involving the intersection of paranoid ideation and competency to stand trial have been presented. Most probably, no other pathological entity raises more intricate questions for the

court than those posed by paranoid conditions. The challenge for the examiner, in terms of determining the extent to which the pathology impinges on the relevant legal requirements, can be impressive. Because of the incidence of paranoid states associated with criminal charges, however, and the seriousness of many of these charges, it is crucial to clarify as much as possible the implications of various paranoid diagnoses for the defendant's capacity to rationally grasp the proceedings and aid his attorney in his defense. This article has explored some of the vagaries encountered with paranoid defendants, as a step toward fuller appreciation of the task of aiding the court in fairly determining competency, and bringing greater preciseness to bear in unraveling the conundrums produced by the paranoid spectrum of disorders.

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Neurocognitive Disorders and the Criminal Justice System: Implications for Assessing and Restoring Competency to Stand Trial for Brain-injured Defendants

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Poster Presentation

Neurocognitive Disorders and the Criminal Justice System: Implications for Assessing and Restoring Competency to Stand Trial for Brain-injured Defendants

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Abstract

Objective: The incidence of serious neuropsychological impairments among persons involved in the criminal justice system is significant and often underreported. Judges frequently order mentally ill and/or brain-injured persons to undergo competency evaluations and restoration treatment according to criteria set forth in **Dusky v. United States**. This study sought to determine incidence rates of neuropsychiatric disorders among criminal defendants ordered to undergo Competency to Stand Trial evaluations. Further, this study evaluated diagnostic differences between those persons adjudicated incompetent and unrestorable to competency and those persons found incompetent and restorable to competency.

Method: Seventy defendants referred for an assessment of their Competency to Stand Trial underwent standardized forensic evaluations, which included neuropsychological screening, the **Diagnostic Interview Schedule**, and the **Competency Assessment Instrument**.

Results: Analysis revealed that 41.5% of the defendants examined were adjudicated as incompetent to stand trial, with the largest percentage (86.2%) of these defendants diagnosed as suffering from Fetal Alcohol Syndrome/Effects, Dementia of varying etiologies, and Schizophrenic Disorders. Further analysis revealed that defendants diagnosed as FAS, Mild MR, Dementia, Head Trauma, and Dementia, Alzheimer's Type were more likely to be adjudicated as incompetent to stand trial and unrestorable to competency than defendants diagnosed as suffering from Schizophrenic Disorders, Substance-Induced Persisting Dementia, or Major Affective Disorders. These latter diagnostic categories were more likely than the former to be responsive to competency restoration efforts such as inpatient psychiatric treatment and educational classes.

Conclusions: Forensic evaluation procedures and competency restoration treatment programs must include neuropsychological screening assessments and treatment techniques. Implications for therapeutic jurisprudence will be discussed.

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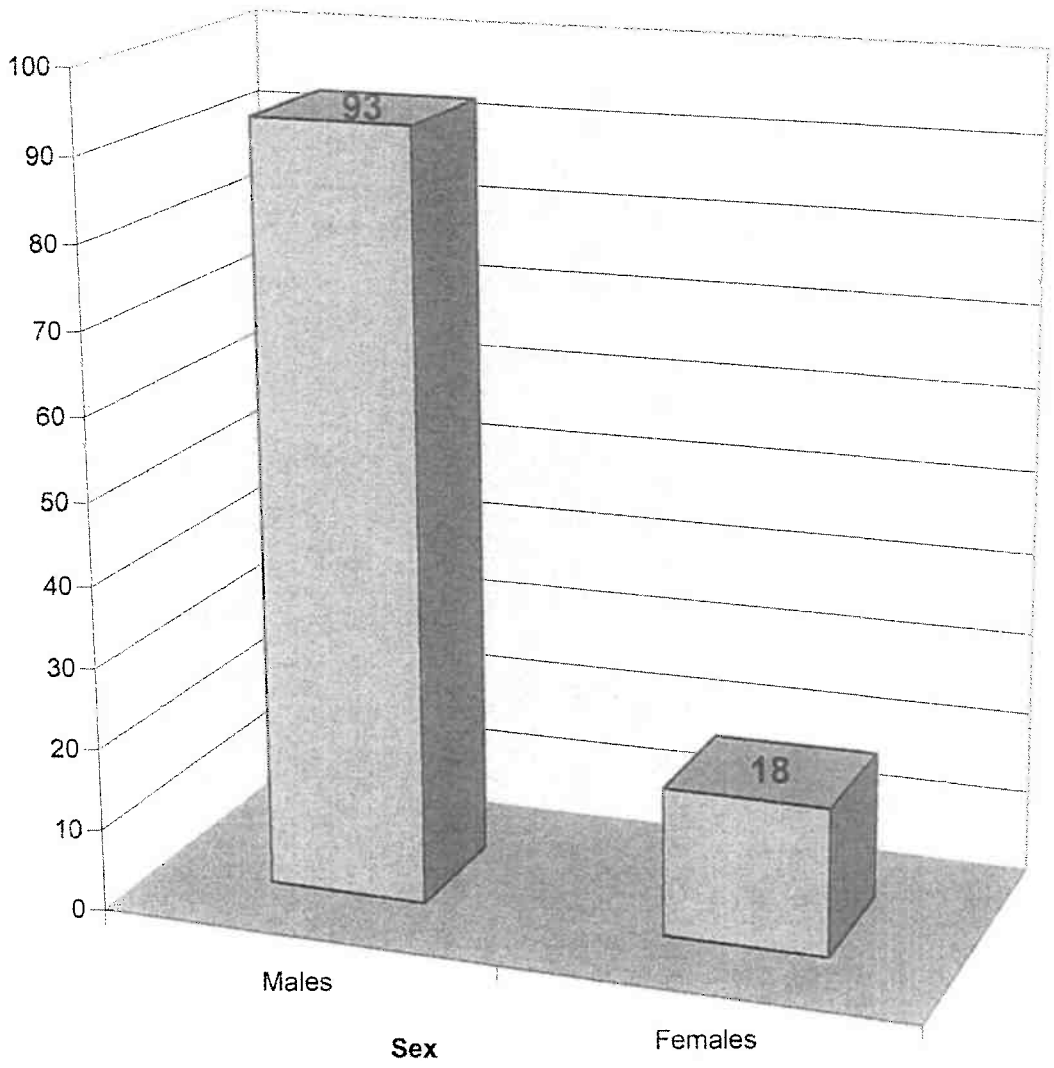
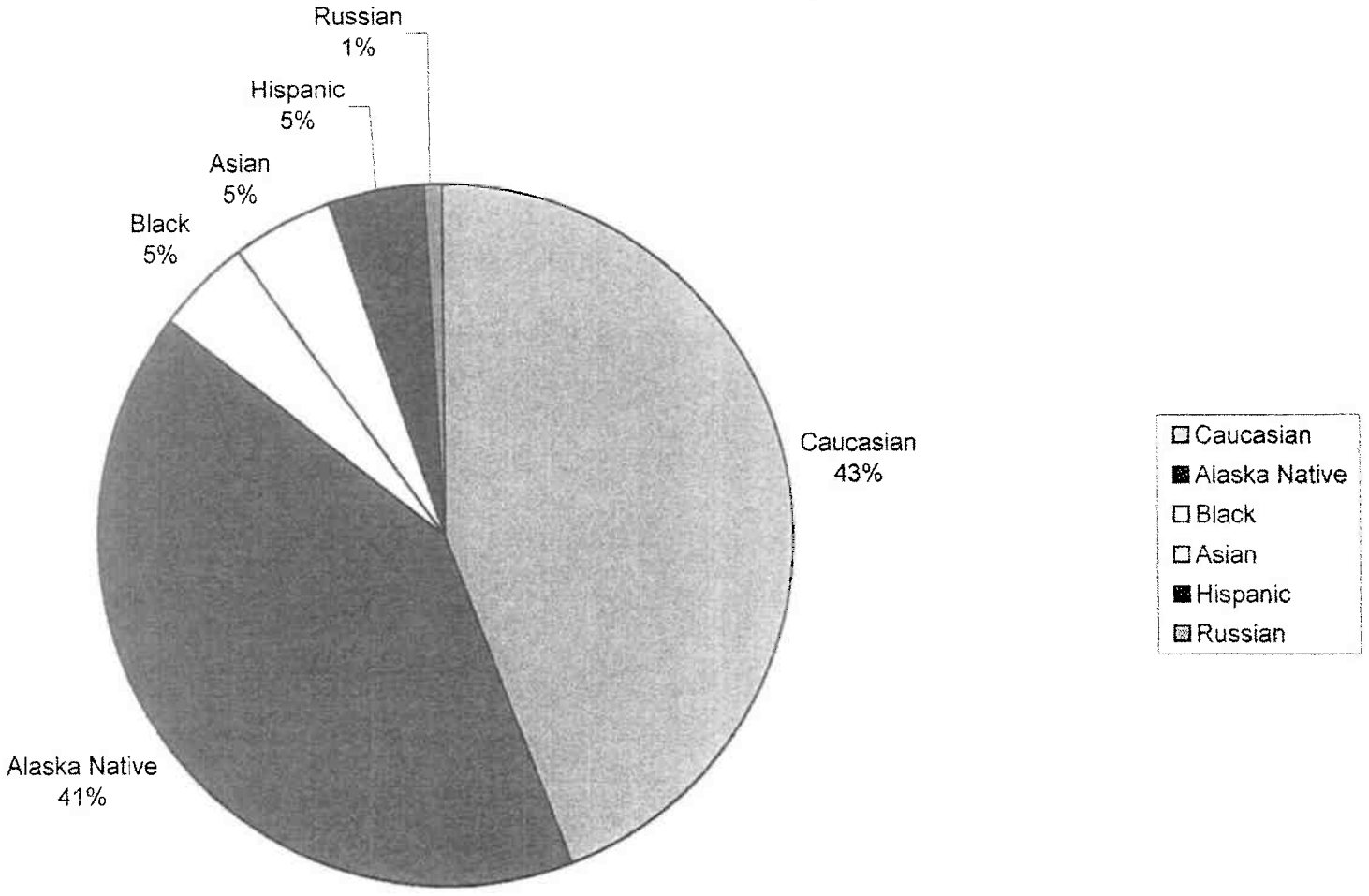
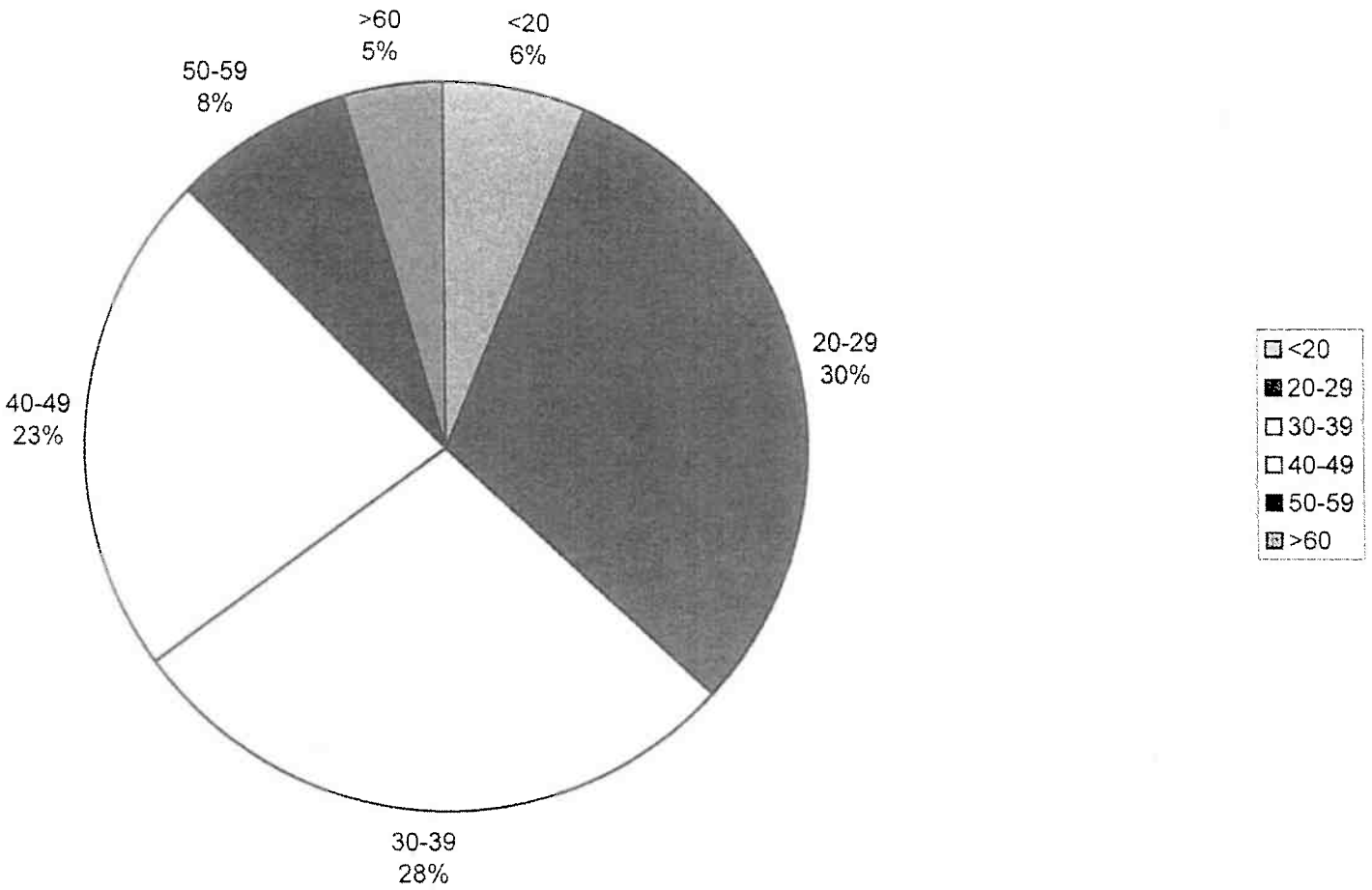
Graph 4: Sex of Defendants Referred for Competency Examination



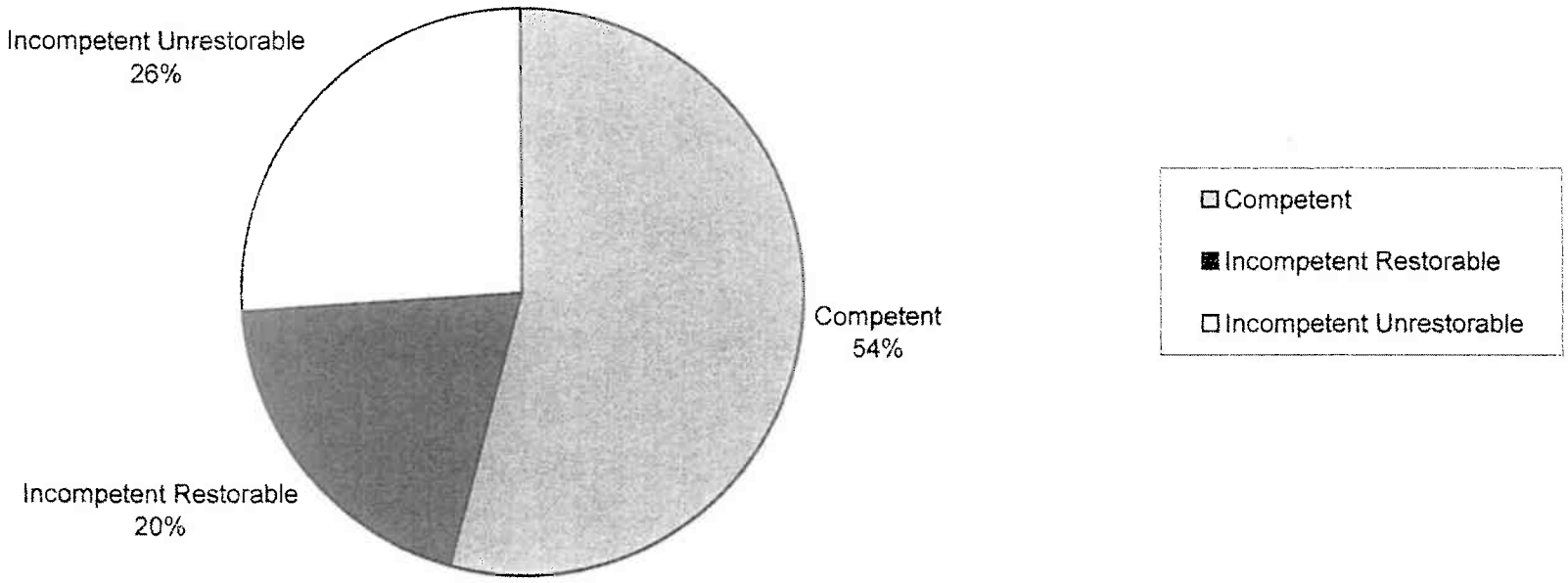
Graph 5: Ethnic Background of Defendants Referred for Competency Examinations



Graph 6: Age Distribution of Defendants Referred for Competency Examinations



Graph 7: Distribution of Competency Examination Outcomes



Graph 9: Substance Abuse Diagnosis of Defendants Referred for Competency Examination

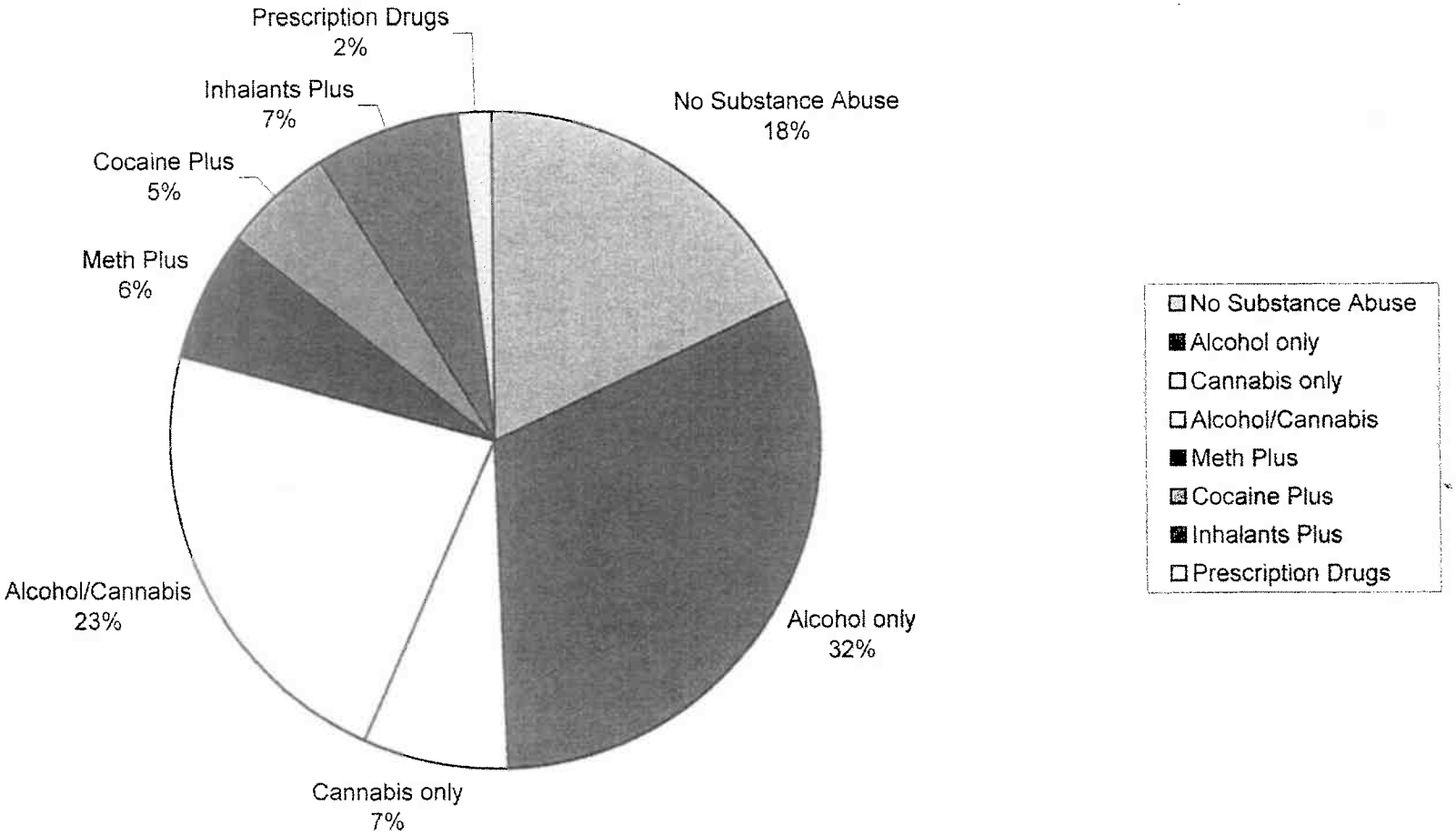


Table 1: Primary Diagnosis by Competency Status

Primary DSM-IV Categories	Competency Status: Competent to Stand Trial (n=60)	Incompetent Restorable (n=22)	Incompetent Unrestorable (n=29)
Affective Disorders (13)			
Bipolar I or II Disorder	3	6	
Major Depressive Disorder	3		
Posttraumatic Stress Disorder	1		
Psychotic Disorders (33)			
Schizophrenia, Paranoid Type	4	6	3
Schizophrenia, Undifferentiated Type	2	1	
Schizoaffective Disorder, Manic Type	2	7	1
Psychotic Disorders, NOS	2	1	
Delusional Disorder	2	1	
Neuropsychiatric/Developmental Disorders (36)			
Fetal Alcohol Syndrome/Effects	5		3
Dementia Due to Head Trauma	1		9
Substance-Induced Persisting Dementia	2		3
Dementia of the Alzheimer's Type	1		3
Mild Mental Retardation	2		6
Borderline Intellectual Functioning	1		1
Substance-Related Disorders (17)			
Alcohol Dependence	2		
Alcohol/Cannabis Dependence	7		
Polysubstance Dependence	6		
Inhalant Abuse/Dependence	2		
Other Disorders (12)			
Antisocial Personality Disorder	9		
Borderline Personality Disorder	1		
Asperger's Disorder	1		
No Diagnosis	1		

Table 2: Criminal Charge by Competency Status

Criminal Charges	Competency Status: Competent to Stand Trial (n=60)	Incompetent Restorable (n=22)	Incompetent Unrestorable (n=29)
Theft	1		2
Sexual Abuse of a Minor	4		1
(Misd) Assault	10	5	8
(Felony) Assault	8	4	4
Trespassing	6	4	3
Sexual Assault	4		2
False Report	1		1
Shoplifting	2		1
Burglary	3	3	1
Illegal Use of Telephone			1
Indecent Exposure	1		1
Failure to Report			1
Minor Consuming		1	1
Disorderly Conduct		1	1
Contributing to the Delinquency			1
Vehicle Theft	1	1	
Probation Violation	1	1	
Murder	5		
Misconduct Involving Weapons	2		
Driving Under Influence	5		
Terroristic Threats	1	1	
Misconduct Involving Controlled Sub.	1		
Malicious Destruction Property		1	
Resisting Arrest	1		
Eluding Arrest	1		
Fraudulent Use of Credit Card	1		
Domestic Violence	1		

October, 1986

The Straits of Insanity in Alaska

Richard R. Parlour, M.D.
David J. Sperbeck, Ph.D.

In 1884, twenty-seven years after purchase of the Alaska Territory from Russia, the U.S. Congress began codifying law in Alaska in an act providing that "the general laws of the State of Oregon now in force are hereby declared to be the law in said district, so far as the same may be applicable and not in conflict with the provisions of this act or the laws of the United States." (Alaska Government Act of 1884, Chapter 53, #7, 23, Statute 25-36, 1884). Fifteen years later Congress specifically approved a criminal code for Alaska, again based primarily on Oregon law (Act of March 3, 1889, Chapter 429, 430, Statute 1253). In the subsequent seven decades Alaska Territorial and State Legislatures amended these basic laws in piecemeal fashion responding to momentary needs, with the inevitable result a hodgepodge of out-dated statutes, obsolete terminology, overly vague or overly specific and sometimes unconstitutional provisions, unsuitable for a modern state. Oregon had revised its own criminal code in 1971.

The ninth Alaska Legislature addressed this problem in 1975, funding the Criminal Code Revision Commission with staff support from the Criminal Justice Center, University of Alaska. The Commission relied for reference on the recently revised criminal codes of Oregon (1973), New York (1975), Arizona (1975), Missouri (1979), Hawaii (1975), Arkansas (1975), Illinois (1972), Washington (1976), and Montana (1975). The New Code, effective January 1, 1980, featured five classes of severity of crimes according to the culpable mental state of the defendant, with uniform penalty provisions for each class; Classes A, B and C for felonies and Classes A and B for misdemeanors (A.S. 11.81.250; A.S. 12.55.035; A.S. 12.55.125; A.S. 12.55.135; A.S. 12.55.140). Judicial discretion in sentencing is allowed for misdemeanants and most first-time felons only; judges may refer cases to a three judge panel when the prescribed sentence seems unjust. Four culpable mental states are defined: *intentionally, knowingly, recklessly* and *criminally negligent*, concepts applied consistently in establishing degrees of severity for various offenses. The Commission recommended only one degree of murder, but the legislature retained the more traditional two degrees of murder differentiated essentially by premeditation in first degree murder. "Heat of passion" is retained as a defense when there was serious provocation by the intended victim; such defendants are guilty of manslaughter (A.S. 11.41.115).

The Culpable Mental States (A.S. 11.81.900)

(1) a person acts *intentionally* with respect to a result described by provisions of law defining an offense when his conscious objective is to cause that result;

(2) A person acts *knowingly* with respect to conduct or to a circumstance described by a provision of law defining an offense when he is aware that his conduct is of that nature or that the circumstance exists; when knowledge of the existence of a particular fact is an element of an offense, that knowledge is established if a person is aware of a substantial probability of its existence, unless he actually believes it does not exist; a person who is unaware of conduct or a circumstance of which he would have been aware had he not been intoxicated acts knowingly with respect to that conduct or circumstance;

(3) a person acts *recklessly* with respect to a result or to a circumstance described by a provision of law defining an offense when he is aware of and consciously disregards a substantial and unjustifiable risk that the result will occur or that the circumstance exists; the risk must be of such a nature and degree that disregard of

it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation; a person who is unaware of a risk of which he would have been aware had he not been intoxicated acts recklessly with respect to that risk;

(4) a person acts with criminal *negligence* with respect to a result or to a circumstance described by a provision of law defining an offense when he fails to perceive a substantial and unjustifiable risk that the result will occur or that the circumstance exists; the risk must be of such a nature and degree that the failure to perceive it constitutes a gross deviation from the standard of care that a reasonable person would observe in the situation.

The code distinguishes between three elements of offenses to which culpable mental states apply: (1) the nature of the conduct; (2) the circumstances surrounding the conduct; and (3) the result of the conduct.

> The first element, conduct, involves the nature of the proscribed act or the manner in which the defendant acts. Kidnapping, for example, requires that one person restrain another. The conduct might be the locking of the only door to a windowless room. *Knowingly* is the culpable mental state applicable to conduct. The second element, circumstances surrounding the conduct, refers to a situation having a bearing on the actor's culpability. Kidnapping requires that the person inside the room not consent to being restrained. Lack of consent is an example of a circumstance crime. *Knowingly, recklessly,* and *criminal negligence* are the culpable mental states associated with the existence of circumstances. The result of the actor's conduct constitutes the final element. Kidnapping can occur if the victim is exposed to a substantial risk of serious physical injury. *Intentionally, recklessly* and *criminal negligence* are the culpable mental states associated with results.

When a statute in the Code provides that a defendant must *intentionally* cause a result, the state must prove that it was the defendant's conscious objective to cause that result. This culpable mental state is comparable to the existing form of culpability commonly referred to as "specific intent." Bribery, for example, requires that the defendant confer a benefit upon a public servant with intent to influence him; the state must prove that it was the conscious objective of the defendant to cause the public servant to be influenced.

Under the Code, *knowledge* requires an awareness on the part of the defendant that his conduct is of the nature described by the statute defining the offense or that the circumstances described by the statute exist. It is not required that the defendant know that his conduct is prohibited by law (*See* A.S. 11.81.620, *supra*). The definition also covers the situation where a person deliberately avoids acquiring knowledge by closing his eyes (sometimes referred to as "willful blindness") by providing that "when knowledge of the existence of a particular fact is an element of an offense, that knowledge is established if a person is aware of a substantial probability of its existence, unless he actually believes it does not exist."

Whether *knowing* should be defined subjectively or objectively was one of the issues most debated by the Subcommission. Under the Code, the test for knowledge is a subjective one - the defendant must actually be aware of the fact critical to culpability or of at least a substantial probability of its existence. A defendant who is unaware of the critical fact or of a substantial probability of its existence does not *know*, regardless of whether a reasonable man would have been aware. Note, however, that a person who is not aware because he is voluntarily intoxicated is held, nevertheless, to have acted *knowingly*.

When a statute in the Code provides that a person must *recklessly* cause a result or disregard a circumstance, criminal liability will result if the defendant "is aware of and consciously disregards a substantial and unjustifiable risk that that result will occur or that the circumstance exists." The test for *recklessness* is a subjective one - the defendant must actually be aware of the risk. On the other hand, if *criminal negligence* is the applicable culpable mental state, the defendant will be criminally liable if he "fails to perceive a substantial and unjustifiable risk that the result will occur or that the circumstance exists." The test for *criminal negligence* is an objective one - the defendant's culpability stems from his failure to perceive the risk.

nature and degree" that either the disregard of it (in the case of *recklessness*) or the failure to perceive it (in the case of *criminal negligence*) constitutes a "gross deviation" from the standard of conduct or care that "a reasonable person would observe in the situation." This definition of the applicable risk involved insures that proof of ordinary civil negligence will not give rise to criminal liability. Sen.J. 139-143 (1978) (emphasis added).

Code Provisions Relating To The Mentally Ill Offender - A Complete Emendation

Effective October 1, 1982, nearly every statute pertaining to the way in which the mentally ill offender is treated by the Alaska criminal justice system was revised. The amendments addressed the diminished capacity issue, the insanity defense, the post-insanity verdict commitment procedures and added a new concept, *guilty but mentally ill.*

The result in Alaska during the first year since the law took effect has reduced the amount of successful insanity pleas to zero and has resulted in a sharp decline in the number of defendants who attempt to plead insanity in any of its forms. We shall see some of the reasons why in this article.

The Diminished Capacity Defense

Prior to the 1982 revisions, Alaska's statute regarding diminished capacity was unremarkable, consistent with the Constitutional principle that the prosecutor must prove all elements of a crime beyond a reasonable doubt, including *mens rea,* the fact that the offender acted on his own volition (In Re Winship, 397 U.S. 358, 1970). The only two legislative attempts to abolish this insanity defense were overturned specifically because they did not allow defendants to contest the existence of *mens rea* (State v. Strasbourg, 110 P. 1021, Wash. 1910; Sinclair v. State, 132 So. 581, Miss. 1931). In the 1982 revisions, Alaska lawmakers took pains to clarify that defendants have access to the diminished capacity defense by asserting any mental illness that would negate the presence of the culpable mental states described above.

> This section recognizes that notwithstanding AS 12.45.083, the state must establish every element of the crime charged against the defendant beyond a reasonable doubt. To the extent that a defendant is able to raise a reasonable doubt that a mental disease or defect made it impossible for him to act with the culpable mental state required for the commission of the crime, this section *requires the defendant to be found not guilty by reason of insanity* regardless of whether the defendant could have established by a preponderance of the evidence the affirmative defense of insanity (emphasis added). (House J. Suppl. #63 at p. 7 (June 1, 1982).)

If a defendant is successful at trial in convincing the factfinder that he lacked the culpable mental state because of mental disease or defect, he is to be found not guilty by reason of insanity. This is a major departure from Alaska law as well as the way the issue has been dealt with all over the United States for the past century.

The apparent reasoning for this change relates to developing law on post-insanity acquittal commitment procedures. Following a successful plea of insanity, in many states, including Alaska, the government has had to meet a lesser burden of proof to commit the defendant to its psychiatric institutions as a result of his dangerous propensities. In normal civil commitment, the government must bear its burden by at least clear and convincing evidence. In post-insanity acquittal commitment procedures, however, the courts have reasoned that since the issue of a defendant's insanity in a criminal case is not reached until after a jury has determined beyond a reasonable doubt that the defendant has perpetrated the acts that would constitute a crime, but for the existence of the insanity defense, the burden may be shifted *to the defendant* to establish his non-dangerousness *(State v. Alto,* 589 P. 2d 402, Alaska 1979).

Alaska's diminished capacity statutes logically extend this rule to the diminished capacity defense, prescribing that a verdict of "not guilty by reason of insanity" results, rather than simply a verdict of "not guilty" which would have been the result under former law. Under prior law, this verdict of "not guilty" would result in the immediate discharge of the defendant. Under present law, the automatic verdict of not

dant's future freedom in substantial doubt with defendant subject to Alaska's very tough criminal commitment procedures which are discussed below.

There is one final consequence to the defense of diminished capacity, a carry-over from prior law, that all lesser included offenses which require a lesser culpable mental state (e.g., manslaughter as a part of murder) must be considered as possible verdicts. Should the factfinder conclude that the defendant had the culpable mental state for a lesser offense, notwithstanding his mental disease or defect, the defendant can still be convicted of the lesser offense. Thus, it is possible under Alaska law for an NGI verdict to be entered for the original charge of first degree murder (as a result of a successful plea of diminished capacity), and a conviction entered instead for manslaughter. In such a situation the defendant would not be released until he has served the prison term for the lesser offense for which he was convicted *and* has proved himself no longer dangerous under Alaska's criminal commitment procedures.

Motions filed at the trial level in the State of Alaska have yet to raise the question of whether these unusual hazards of the diminished capacity defense violate any constitutional principles.

The Insanity Defense

The Alaska Legislature sharply curtailed the definition of the defense of insanity. It provided in A.S. 12.47.010:

> Insanity Excluding Responsibility
>
> (a) In a prosecution for a crime, it is an affirmative defense that when the defendant engaged in the criminal conduct, the defendent was unable, as a result of a mental disease or defect, to appreciate the nature and quality of that conduct.

This definition is substituted for the prior American Law Institute definition (defendant was unable to appreciate the wrongfulness of his conduct or conform his conduct to the requirements of law). The Alaska Legislature narrowed even the old M'Naghten test, discarding its final phrase, that the defendant must know that what he was doing was wrong. Alaska's version of the insanity defense now exculpates he was doing.

The intent of the legislature to thus limit the insanity defense is clear in its commentary:

> By limiting the defense to cases where the defendent is unable to appreciate the nature and quality of his conduct, this legislation enacts one branch of the *M'Naghten* test of insanity. That portion of the *M'Naghten* test which defines legal insanity as including situations where the defendant did not know the wrongfulness of his conduct is specifically rejected by this legislation and excluded from the revised definition of legal insanity. The fact that the defendant did not appreciate the wrongfulness of his conduct, nevertheless may be relied upon to establish that the defendant was "guilty but mentally ill" under A.A. 12.47.030.
>
> An example of a person who could successfully establish the elements of the revised insanity defense is the defendant who, as a result of a mental disease or defect, is unable to realize that he is shooting someone with a gun when he pulls the trigger on what he believes to be a water pistol, or a murder defendant who believes he is attacking the ghost of his mother rather than a living human being. Conversely, this defense would *not* apply to the defendant who contends that he was instructed to kill by a hallucination, since the defendant would still realize the nature and quality of his act, even though he thought it might be justified by a supernatural being. Such a defendant could be determined guilty but mentally ill under A.S. 12.47.030. (House J. Suppl. #68 at p. 6, June 1, 1982).

There is little dispute that the narrowing of the defense to this degree will sharply limit the availability of the defense. Critics might contend that this provision so severely restricts the insanity defense that is it tantamount to abolishment. There are certainly some delusional crimes that would quality for consideration of the insanity defense even as defined by Alaska, but these would be excused because of *mens rea* requirements. The insanity defense in Alaska may be superfluous, as presently defined.

Guilty But Mentally Ill

For the first time in its history, Alaska provided

had previously become law in several other states including Michigan, Illinois and Georgia (1972 Mich. Pub. Acts 180, Pl). The term encompasses a largely different concept in Alaska, however.

Alaska reinserted the former test for insanity, the ALI test, as the test for the verdict of guilty but mentally ill (A.S. 12.47.030(a)). Nearly all of the defendents who were formerly successful at pleading the insanity defense will now be found guilty but mentally ill under Alaska law. This verdict makes mental illness heretofore an issue in the adjudication of guilt or innocence, now an issue in the disposition of the defendant at sentencing. This is how the legislature's commentary describes the intended function of this verdict:

> Under this new limited affirmative defense of insanity, many persons who would have been found not guilty by reason of insanity under former A.S. 12.45.083 will now be found guilty and sentenced under the criminal law like any other defendant. A.S. 12.47.050 recognizes, however, that rehabilitation and eventual reintegration of such persons into society must be premised on a program of mental health care. For these people, the new law provides for a jury verdict of "guilty but mentally ill". This verdict is entered when the defendant, although not meeting the new definition of insanity, would meet the ALI test for the former law. Section 12.47.050 makes it mandatory for the Department of Health and Social Services to provide mental health treatment for a person who is "guilty but mentally ill." (House J. Supp. at p. 5; June 1, 1982).

Before this new provision, psychiatric service to prisoners was at the discretion of prison authorities, and minimal at best, a characteristic of U.S. prisoners generally (Parlour & Sperbeck, 1984). A common argument in favor of the GMI verdict nationally is that the required psychiatric treatment of defendants so convicted will make mental health service more available to all prisoners. Conversely, it is argued that all available mental health facilities will be focused on GMI's to the detriment of other prisoners (American Psychiatric Association Statement on the Insanity Defense, Dec. 1982). In Michigan's nine year experience with a GMI statute, there [illegible] to improve [illegible] health service for GMI prisoners or the Michigan Correctional System, as a whole.

Almost two years after the new mentally ill offender statute became law in Alaska, the first GMI convicts are presenting themselves for the mandatory treatment at the state hospital. No special program or facility has been designated for this purpose. The already over-utilized maximum security unit at the hospital is expected to serve this new patient population.

Notice also that the new statute specifically forbids work release or furlough modalities during the treatment phase of incarceration for GMI's. While at the hospital, they are limited to the maximum security unit. Those convicts who are simply guilty have options for parole with outpatient treatment and other opportunities specifically denied to GMI's in active treatment.

The GMI verdict may be moved by the prosecution and/or the court itself even when defendants have not raised the mental illness issue in any form. GMI defendants must prove themselves not dangerous before they can be processed in prison like other convicts; the rules of such proof are the same as for NGI's (see below).

Post-Insanity Commitment Procedures

A.S. 12.47.090 prescribes specially stringent commitment procedures following a verdict of not guilty by reason of insanity resulting from either the diminished capacity or insanity defense. The *defendant* bears the burden by clear and convincing evidence to prove he is no longer a danger to the public peace or safety as a result of *any presently existing* mental illness (A.S. 12.47.090(C).) This is an onerous burden since the absence of dangerousness is difficult to prove, and a striking contrast to civil commitment procedures in which the government has the burden of establishing such dangerousness.

Furthermore, when the defendant first raises the insanity defense, a request for hearing for his release from this criminal commitment is [illegible] automatically included. In other words, prior to the criminal trial, the defendant must assert that he no longer is suffering from a

mental disease or defect that causes him to be dangerous to the public peace or safety. The statute contemplates that the same trier of fact who hears the evidence surrounding the criminal offense will also hear the post-acquittal commitment case. Thus, the jury or judge will have heard all of the evidence concerning the commission of the alleged crime before deciding whether defendant is still dangerous.

The legislative commentary specifically deletes a number of psychiatric disorders from consideration in the insanity defense as follows:

> The terms used to define "mental disease or defect" in A.S. 12.47.130, are taken from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, 3rd Edition (1980) (D.S.M. III). The term is intended to include those major mental disorders such as schizophrenia, severe mood disorders or profound organic mental disorders which substantially impair a person's ability to perceive reality or adapt to it.
>
> There are many mental disorders defined in psychiatry, however, which, though they affect behavior, are not of the severity or magnitude necessary to qualify under this definition. Examples of these disorders would be drug addictions, post-traumatic stress disorders, conduct disorders, dissociative disorders, psychosexual disorders and impulse control disorders. Voluntary intoxication or drug withdrawal states, regardless of their severity, would not qualify as a "mental disease or defect." (House J. Supp. at p. 6, June 1, 1982)

Even if defendant has an acceptable "mental disease or defect", he must affirmatively prove he did not know he was committing the criminal act, the cognitive test previously described for NGI's.

The term mental disease or defect is not used, however, in A.S. 12.47.090 relating to post-insanity acquittal commitment procedures. The term used instead is "mental illness." It is defined as follows:

> (1) "Mental illness" means any mental condition that increases the propensity of the defendant to be dangerous to the public peace or safety; however, it is not required that the mental illness be sufficient to exclude criminal responsibility under A.S. 12.47.010, or that the mental illness presently suffered by the defendant be the same one the defendant suffered at the time of the criminal conduct;

The definition of dangerousness for purposes of post-insanity acquittal commitment proceedings is also specifically prescribed (A.S. 12.47.090 (j)(2)):

> (2) "dangerous" means a determination involving both the magnitude of the risk that the defendant will commit an act threatening the public peace or safety, as well as the magnitude of the harm that could be expected to result from this conduct; a finding that a defendant is "dangerous" may result from a great risk of relatively slight harm to persons or property, or may result from a relatively slight risk of substantial harm to persons or property.

The analysis of "dangerousness" that is contemplated by the statute, reading the statute together with its commentary, is similar to the risk analysis that might be employed in travel planning. The FAA might very well ground a DC-10 even though the probability that the plane will crash is extremely low. The amount of loss of life to passengers in the event of a plane crash is so great that the very low degree of probability is tolerated. Conversely, if one were deciding to take a trip in an automobile and the concern was whether the tire would go flat, a much higher degree of probability that the event would take place would be acceptable. The commentary states:

> Paragraph (j) (2) provides the court with a formula for assessing dangerousness. The court is to consider both the risk that the defendant will commit harmful acts, as well as the magnitude of the harm that could be expected. For example, the court should require a greater risk that the defendant will commit acts involving only harm to property, but can rest a determination of dangerousness upon substantially less likelihood of future acts, if the defendant's future acts can be expected to involve the infliction of serious physical injury.

It is apparent that the definitions used above for "mental disease or defect" include those disorders in the DSM III which are commonly

[illegible] to cause the results described in the diminished capacity and insanity defense statutes. Since dangerousness, however, can result from a much broader category of diagnoses, a vastly expanded definition applies to post-insanity acquittal commitment procedures.

It comes as no surprise that there have been no NGI verdicts under the new law. Any responsible attorney would have to conclude that the standards for release under A.S. 12.47.090 are extremely difficult to meet. Most defendants would be better off taking their chances on a fixed sentence following a criminal conviction rather than facing the prospect of proving their nondangerousness by clear and convincing evidence, given these definitions.

A defendant found simply guilty of violence against persons can hope to leave prison with good conduct long before serving the maximum sentence. He can even demand mental health services in prison mandated by a recent consent decree (Cleary v Alaska, 1983). The NGRI defendant will be confined for the maximum sentence unless he can prove himself no longer dangerous, utilizing these very comprehensive definitions of dangerousness that provide almost no limitation of judicial discretion.

Incompetency To Proceed

The 1982 amendments also address defendants' competency, but in a manner more favorable to defendants. The competency proceedings and defendant's self-incriminating statements therein may not be brought to the attention of juries in the subsequent trial in chief. After 180 days' commitment for incompetency, charges against the incompetent shall be dismissed without prejudice and civil commitment procedures instituted. After five years of incompetency, the charges may not be reinstated unless the original charge was a Class A or unclassified felony. Successfully medicated defendants may not be denied trial because of taking medicine.

Formulating Opinions About Mentally Ill Offenders In Alaska

The following decision-tree has been developed to help psychiatrists provide useful opinions under the new Alaska statute:

A. Diminished Capacity

With respect to the primary charge o charges, at time of the offense did the de fendant have the capacity to form the cul pable mental state (knowledge, intent negligence, recklessness, depending upo the offense charged) required by the charge

1. If the defendant could form the culpabl mental state for the offense he is accused of so state and go on to B.

2. If defendant did not have the culpabl mental state for the offense charged, th examiner should consult counsel abou lesser and included charges possible in th case, and give opinions about existence o culpable mental states for these lesser and included charges.

B. Insanity

The examiner will give opinions abou whether the defendant *generally* knew th nature and quality of his actions at th time of the instant offense or offenses.

C. Guilty but Mentally Ill

The examiner will give opinions abou application of the ALI rules in the case Defendant did not know he was doing wrong and/or could not conform his con duct to the requirements of law.

D. Present Dangerousness

The examiner will give opinions about th defendant's present dangerousness. (De fendants wholly or partially exculpated under the Alaska Insanity Statute must b adjudicated as to present dangerousnes to complete the trial. The examiner mus use Criminal Commitability criteria here.)

E. Competency to Proceed

The usual criteria apply (Dusky v. U.S., 362 U.S. 402, 1960).

F. Recommendations for Dispostion

Discussion

Although the public tends to see the insanity defense as an easy way out, defense lawyers use it reluctantly and only on their most unsympathetic cases. Lawyers know that the definitions of insanity are far less important to

verdicts, the procedural infrastructure behind the insanity concept. The most critical issue, seldom debated in public, is how the acquitted insane regain their freedom. Hardly noticed in the ballyhoo about insanity definitions and psychiatric testimony was the extension of recently adopted civil commitment criteria to NGI's in some states, such as Arkansas, where the state psychiatrists have been running to court every few weeks, trying to prove that their NGI's are still manifesting dangerous behavior day-to-day without reference to their past offenses. Only the most recalcitrant patients fail to achieve passive compliance with hospital routines (taking high doses of antipsychotic medication) long enough to meet civil commitment standards. To hold such dangerous patients, conscientious judges had to stretch the civil commitment law beyond credible limits, risking impeachment, and conscientious psychiatrists spent as much time on legal procedure as clinical work. It is hard to believe that such happenings were the intent of an informed legislature. One must reflect on the inherent pitfalls of legislative procedure and the relative unimportance of criminal matters compared to roads and schools.

Such carelessness is clearly not the case with respect to the 1982 revisions of the Alaska Penal Code, which are unusually thorough, sophisticated, consistent and well explained. They are so stacked against defendants that one can hardly imagine a case where a defendant would make the insanity defense except to avoid execution. There is no death penalty in Alaska and there have been no insanity pleas in the 21-month life of these revisions. The GMI verdict is virtually an instrument of the prosecution in felony cases because of the special burdens it imposes on defendants. No constitutional challenges have yet been raised despite the many unusual features of the new law; the challenges that will surely come whet the appetite of legal scholars.

Meanwhile, in two years, Alaska has made no new provision for the additional mental health services required under this law.

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